

# Child Care Registration Form

## For Office Use Only

Date Contacted \_\_\_\_\_

Start Date Confirmed \_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Program

Program (circle):            Infant Care            Preschool

Preferred Facility Start Date \_\_\_\_\_ Confirmed Facility Start Date \_\_\_\_\_

## General Information

Child First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Nick Name \_\_\_\_\_

Weight \_\_\_\_\_

Height \_\_\_\_\_

Sex (circle)    M    F    Other \_\_\_\_\_

Date of Birth \_\_\_\_\_

## Special Needs and Subsidy Information

Subsidy Number \_\_\_\_\_

Subsidy Start Date \_\_\_\_\_ Expiry Date \_\_\_\_\_

Restrictions:  
\_\_\_\_\_

## Primary Contact (Parent/ Guardian)

First Name \_\_\_\_\_ Last name \_\_\_\_\_

Pronouns \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Caregiver (Circle)                      YES                      NO

Address \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Comments \_\_\_\_\_

Cell Phone \_\_\_\_\_ Comments \_\_\_\_\_

Work Phone \_\_\_\_\_ Comments \_\_\_\_\_

E-mail \_\_\_\_\_

Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_ Postal Code \_\_\_\_\_

Days & Hours Work \_\_\_\_\_

Circle all relevant:

Emergency Contact                      Lives With                      Pick up Authority                      Restraining Order

## Contact (Parent/ Guardian)

First Name \_\_\_\_\_ Last name \_\_\_\_\_

Pronouns \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Caregiver (Circle)                      YES                      NO

Address \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Comments \_\_\_\_\_

Cell Phone \_\_\_\_\_ Comments \_\_\_\_\_

Work Phone \_\_\_\_\_ Comments \_\_\_\_\_

E-mail \_\_\_\_\_

Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_ Postal Code \_\_\_\_\_

Days & Hours Work \_\_\_\_\_

Circle all relevant:

Emergency Contact                      Lives With                      Pick up Authority                      Restraining Order

## Other Contact

First Name \_\_\_\_\_ Last name \_\_\_\_\_

Pronouns \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Caregiver (Circle)                      YES                      NO

Address \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Comments \_\_\_\_\_

Cell Phone \_\_\_\_\_ Comments \_\_\_\_\_

Work Phone \_\_\_\_\_ Comments \_\_\_\_\_

E-mail \_\_\_\_\_

Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_ Postal Code \_\_\_\_\_

Days & Hours Work \_\_\_\_\_

Circle all relevant:

Emergency Contact                     
  Lives With                     
  Pick up Authority                     
  Restraining Order

## Other Contact

First Name \_\_\_\_\_ Last name \_\_\_\_\_

Pronouns \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Caregiver (Circle)                      YES                      NO

Address \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Comments \_\_\_\_\_

Cell Phone \_\_\_\_\_ Comments \_\_\_\_\_

Work Phone \_\_\_\_\_ Comments \_\_\_\_\_

E-mail \_\_\_\_\_

Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_ Postal Code \_\_\_\_\_

Days & Hours Work \_\_\_\_\_

Circle all relevant:

Emergency Contact                     
  Lives With                     
  Pick up Authority                     
  Restraining Order

## Siblings

Sibling First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Program/ School \_\_\_\_\_

Sibling First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Program/ School \_\_\_\_\_

Sibling First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Program/ School \_\_\_\_\_

## Health and Medical Information

MHSC No. \_\_\_\_\_ PHN No. \_\_\_\_\_ Health Plan No \_\_\_\_\_

Allergies/ Medical conditions

\_\_\_\_\_

Diagnosis Agency \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_

Agency Involved (Circled)                      YES                      NO

Special Needs Diagnosis

\_\_\_\_\_

Tested for senses (Circle)                      YES                      NO

Required Treatment \_\_\_\_\_

\_\_\_\_\_

Treatment Details \_\_\_\_\_

\_\_\_\_\_

Other Information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Growth and Development

Eating habits

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Food Dislikes

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Food Likes

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Languages Spoken

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Dominant Hand

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Nap information

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Dressing Help Info

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Toilet Help Info

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Favourite Activity

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## Growth and Development (continued)

### Playing Habits

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### Playing Difficulties

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### Friends

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### Previous Care

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### Guidance Method

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### Other Info

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## Family Physician

Title \_\_\_\_\_

First Name \_\_\_\_\_ Last name \_\_\_\_\_

Agency Name \_\_\_\_\_ Position \_\_\_\_\_ Field of Expertise \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Comments \_\_\_\_\_

Cell Phone \_\_\_\_\_ Comments \_\_\_\_\_

Work Phone \_\_\_\_\_ Comments \_\_\_\_\_

Alternate Phone \_\_\_\_\_ Comments \_\_\_\_\_

E-mail \_\_\_\_\_

Fax \_\_\_\_\_ Employer Name \_\_\_\_\_

Comments

\_\_\_\_\_

\_\_\_\_\_

## Other Consultant, Physician, Therapist

Title \_\_\_\_\_ Occupation \_\_\_\_\_

First Name \_\_\_\_\_ Last name \_\_\_\_\_

Agency Name \_\_\_\_\_ Position \_\_\_\_\_ Field of Expertise \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Comments \_\_\_\_\_

Cell Phone \_\_\_\_\_ Comments \_\_\_\_\_

Work Phone \_\_\_\_\_ Comments \_\_\_\_\_

Alternate Phone \_\_\_\_\_ Comments \_\_\_\_\_

E-mail \_\_\_\_\_

Fax \_\_\_\_\_ Employer Name \_\_\_\_\_

Comments

\_\_\_\_\_

## Schedule

Arrival Time _____	Departure Time _____	Days (circle)	M	T	W	Th	F
Arrival Time _____	Departure Time _____	Days (circle)	M	T	W	Th	F
Arrival Time _____	Departure Time _____	Days (circle)	M	T	W	Th	F
Arrival Time _____	Departure Time _____	Days (circle)	M	T	W	Th	F

Comments

\_\_\_\_\_

\_\_\_\_\_

## Child Care Pro Consent

Child Care Pro is a program used by Inspired by Wonder to store your child's information for our reference. We hereby request your consent to disclose the collected information to Vari Tech Systems Inc. for the purpose of managing the software Childcarepro on behalf of The Facility and in accordance with the Vari Tech Privacy Cod. I understand the Vari Tech systems Inc. will not disclose such personal information without my further consent unless required or permitted by the law.

For additional information about the Vari Tech Privacy Code please visit [www.varitechsystems.com](http://www.varitechsystems.com) or contact the Vari Tech Privary Officer at 204-231-7068 or by email at [admin@childcarepro.ca](mailto:admin@childcarepro.ca)

Date \_\_\_\_\_ Signatures \_\_\_\_\_

## Emergency

If at any time, medical treatment is necessary due to a serious injury or sudden illness. I authorize the childcare facility to take whatever emergency measures deemed necessary for the protection of my child while in the care of the child care facility. I give permission for my child to receive medical attention deemed necessary by my child's doctor or other medical personnel. I understand that this may involve transportation to the hospital in a private vehicle or ambulance. I understand that the facility will make every attempt to contact me and that any expense incurred for such treatment, including ambulance fees, is my responsibility

Date \_\_\_\_\_ Signatures \_\_\_\_\_

## Field Trips

I give permission for my child to accompany the Facility on field trips. I understand that this includes excursions on foot, or on public transportation. (i.e. local parks/playgrounds). Advance notice will be given and individual permission requested.

Date \_\_\_\_\_ Signatures \_\_\_\_\_



## Indirect Supervision

I give permission for indirect supervision for the infant sleep area.

Date \_\_\_\_\_ Signatures \_\_\_\_\_

## Learning Stories

I give the facility permission to take pictures of my child for Learning Story Documentation purposes. If there is a story completed or written on my child it may be sent home for family input and is to be sent back to the facility. I also understand that other children may be in the pictures and they will need to be kept in confidence. These Learning Stories will also be posted on the Facilities bulletin boards for all to view. These pictures may not be copied/scanned without the express consent of the Executive Director.

Date \_\_\_\_\_ Signatures \_\_\_\_\_

## Media

I give the facility permission, at the discretion of the Executive Director and/or Assistant Director, for photos or videos of my child to be used for the purpose of media (i.e. newspaper, television, SSCY collaborative services, social media, blogs, and/ or childcare website).

Date \_\_\_\_\_ Signatures \_\_\_\_\_

## Medicine

I will make every attempt to administer medication to my child at home. In the event that the medication needs to be administered during Facility hours, the following conditions will be respected:

- The medicine will be prescribed by a medical doctor
- Will be provided to a staff member in the original container with a legible prescription indicating the date, doctor's name, dosage, and instructions

I will sign a further, more detailed medicine consent form at that time.

Date \_\_\_\_\_ Signatures \_\_\_\_\_

## Parent Manual

I have received and read the parent manual. I understand and agree to abide by these policies.

Date \_\_\_\_\_ Signatures \_\_\_\_\_

## Photos/ Videos

I give permission for the Facility's staff to take pictures/ videos of my child for Facility use only. I agree to the centre sending pictures of children doing various activities pertaining to the grants that we may receive. These pictures may also be sent to photo stores (i.e. Walmart or Costco) for printing and making our photo books.

Date \_\_\_\_\_ Signatures \_\_\_\_\_

## Practicum

I give permission for my child to be observed by students in the fields of early childhood education or specialized services (including but not exclusive to occupational therapy, speech and language pathology, physiotherapy, and child development. This may include medical students.) if these observations are kept in confidence and used only as a means to fulfill their course requirements. These observations must be approved by the Facility. These observations may include written or photo documentation.

Date \_\_\_\_\_ Signatures \_\_\_\_\_

## Release of Information

I authorize the release of any information or records requested to the staff of the Facility. This information will generally be requested from schools or other professionals that are or have been involved with the child.

Date \_\_\_\_\_ Signatures \_\_\_\_\_

## Sunscreen/ Bug Spray

I hereby authorize the Facility to apply SUNSCREEN SPF 30+ and Bug Spray on my child during the season when children are at risk of the sun and bug bites. I am aware that I will be required to sign in June for a nominal fee to be applied to my account. If I wish my child to use special sunscreen/bugspray I will need to provide a bottle to the child care centre.

Date \_\_\_\_\_ Signatures \_\_\_\_\_

## Withdrawal

I am aware that I must provide the Facility with two (2) weeks written notice before withdrawing my child. If I fail to do this, I will be required to pay for two(2) weeks of fees and I will forfeit my deposit.

Date \_\_\_\_\_ Signatures \_\_\_\_\_