



550 ROBERTSON STREET
WINNIPEG, MANITOBA R2X 2C4
T 204-586-7950 | F 204-589-7293

Child Care Registration Form

For Office Use Only

Date Contacted _____ Start Date Confirmed _____

Notes: _____

Program

Program (circle): Nursery Kindergarten 1& 2 Period Care Summer Only

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

Food Dislikes

Food Likes

Languages Spoken

Dominant Hand

Nap information

Dressing Help Info

Toilet Help Info

Favourite Activity

Growth and Development (continued)

Playing Habits

Playing Difficulties

Friends

Previous Care

Guidance Method

Other Info

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 or contact the Vari Tech Privary Officer at 204-231-7068 or by email at 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.

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 _____