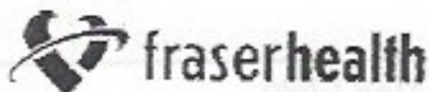

Sandpiper Preschool

Registration Form for Child Care

FACILITY NAME:	
FULL NAME OF CHILD:	USUAL NAME OF CHILD [IF DIFFERENT]:

Personal Information

CHILD'S DATE OF BIRTH:	GENDER:	STARTING DATE:
ADDRESS:		POSTAL CODE:
		PHONE: ( )

PARENT OR GUARDIAN:	PARENT OR GUARDIAN:
ADDRESS [IF DIFFERENT FROM ABOVE]:	ADDRESS [IF DIFFERENT FROM ABOVE]:
PHONE:	PHONE:
WORK ADDRESS/ALTERNATE LOCATION:	WORK ADDRESS/ALTERNATE LOCATION:
PHONE [INCLUDE LOCAL]:	PHONE [INCLUDE LOCAL]:
CELLULAR/PAGER:	CELLULAR/PAGER:
HOURS AT THIS LOCATION:	HOURS AT THIS LOCATION:

Emergency Health Information

CARE CARD NUMBER:			
FAMILY DOCTOR/CLINIC NAME:		FAMILY DENTIST/CLINIC NAME:	
ADDRESS:	PHONE:	ADDRESS:	PHONE:

Consent for Emergency Care

I authorize the staff at the child care centre to call a medical practitioner or ambulance in the case of accident or illness of my child(ren), if the parent cannot immediately be reached.

SIGNATURE OF PARENT/GUARDIAN:	DATE:
MANAGER OF FACILITY:	

Person(s) Authorized to Pick Up Child

(other than parent/guardian listed above)

NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

Persons(s) not Authorized to Pick Up Your Child

NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

Custody Agreement:

☐ YES ☐ NO

IF YES, SUPPLY A COPY OF THE CUSTODY ORDER TO THE FACILITY MANAGER/LICENSEE

ALTERNATE PERSON(S) TO CALL AND PICK UP CHILD IN CASE OF EMERGENCY

NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

Child's Immunization Status

(Please record dates [year/month/day] or attach copy of immunization)

IS YOUR CHILD UP TO DATE ON IMMUNZATIONS? ☐ YES ☐ NO ☐ NOT IMMUNIZED

DIPHTHERIA	PERTUSSIS	TETANUS	POLIO	MMR (Measles/Mumps/Rubella)	HIB
1.	1.	1.	1.	1.	1.
2.	2.	2.	2.	2.	2.
3.	3.	3.	3.		
4.	4.	4.	4.		
5.	5.	5.	5.		

COMMENTS:

Health Information

[Please attach a separate sheet, if necessary]

REGULAR MEDICATION[S] AND REASONS FOR [PLEASE LIST]:

ALLERGIES AND TREATMENT OF [PLEASE LIST]:

INJURY(S), ILLNESS(ES) OR OPERATIONS YOUR CHILD HAS HAD AND INCLUDE DATE(S):

a) Please describe any concerns/issues regarding your child's health (seizures, asthma, vision, hearing, etc.)

b) Please describe any concerns you may have regarding your child's development [i.e., behaviour, vision, hearing, speech, language, mobility, etc.]:

c) Describe any specific care instruction regarding a) and/or b):

OTHER HEALTH CARE PROFESSIONALS INVOLVED IN YOUR CHILD'S LIFE, E.G., OCCUPATIONAL THERAPIST/PHYSICAL THERAPIST:

Group Experiences

WHAT IS/ARE YOUR CHILD'S FAVOURITE TOY(S)/ACTIVITIES:

HAS YOUR CHILD HAD PREVIOUS PLAY GROUP EXPERIENCE? ☐ YES ☐ NO

IF YES, HOW DID HE/SHE ADAPT?

HOW DOES YOUR CHILD BEHAVE TOWARD OTHER CHILDREN [E.G., SEEKS OTHERS OUT, FEELS SHY]:

Emotional

HOW DOES YOUR CHILD REACT WHEN LEFT WITH UNFAMILIAR PEOPLE AND/OR IN UNFAMILIAR SITUATIONS?

DOES YOUR CHILD HAVE ANY PARTICULAR FEARS? PLEASE DESCRIBE:

WHAT SUGGESTIONS DO YOU HAVE THAT WOULD HELP STAFF MAKE YOUR CHILD'S TRANSITION INTO THIS PROGRAM EASIER?

Family and General Household Information

PLEASE LIST THE NAMES OF THE SIGNIFICANT PEOPLE IN YOUR CHILD'S LIFE [E.G., SIBLINGS, GRANDPARENTS, ETC.]:

PLEASE DESCRIBE THE GUIDANCE AND DISCIPLINE METHODS USED AT HOME:

PRIMARY LANGUAGE SPOKEN IN THE HOME:	OTHER LANGUAGES:
NAME OF ENGLISH SPEAKING PERSON [IF NEEDED]:	PHONE:

Any Other Comments

Signature of Parent or Guardian Providing Information		
SIGNATURE:	PRINT NAME:	DATE:

NOTE: This information may be reviewed by Fraser Health Authority Licensing staff as per legislation.

Facility Use Only		
Staff person reviewing family's documents:		
SIGNATURE:	PRINT NAME:	DATE:
CHILD'S WITHDRAWAL DATE:	REASON FOR WITHDRAWAL:	