fraserhealth

COMMUNITY CARE FACILITIES LICENSING

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 ☐ Male ☐ Female	STARTING DATE
ADDRESS		FACILITY USE ONLY WITHDRAWAL DATE
POSTAL CODE	TELEPHONE ( )	

PARENT OR GUARDIAN	PARENT OR GUARDIAN
ADDRESS *(if different from above)*	ADDRESS *(if different from above)*
TELEPHONE ( )	TELEPHONE ( )
WORK ADDRESS / ALTERNATE LOCATION	WORK ADDRESS / ALTERNATE LOCATION
TELEPHONE *(Include Local / Extension)* ( )	TELEPHONE *(Include Local / Extension)* ( )
CELL PHONE / PAGER ( )	CELL PHONE / PAGER ( )
HOURS AT THIS LOCATION	HOURS AT THIS LOCATION

EMERGENCY HEALTH INFORMATION

CARE CARD NUMBER	
FAMILY DOCTOR / CLINIC NAME	DOCTOR / CLINIC TELEPHONE ( )

CONSENT FOR EMERGENCY CARE

I authorize the staff at the child care centre to call a medical practitioner or ambulance / transport child to emergency medical care, in the case of accident or illness of my child(ren), if the parent cannot immediately be reached. Yes ☐ No ☐

ALTERNATE PERSONS(S) AUTHORIZED TO PICK UP CHILD *(other than parent/guardian listed above, include emergency pickup)*

Check all that apply

Name	Relationship	Telephone	Authorized to Pickup	Authorized to Call in an Emergency
			☐	☐
			☐	☐

PERSONS(S) WHO ARE NOT PERMITTED ACCESS TO MY CHILD

Name	Relationship	Telephone

CUSTODY OR OTHER LEGAL ORDERS

Yes ☐ No ☐	If yes, supply a copy of the order to the facility Manager / Licensee

CHILD'S IMMUNIZATION STATUS

Is your child up to date on immunizations? Yes ☐ No ☐ Not Immunized ☐

COMMENTS

HEALTH INFORMATION *(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)

1. Please describe any concern(s) / issues regarding your child's health (seizures, asthma, vision, hearing, etc).
2. Please describe any concerns you may have regarding your child's development (i.e. behaviour, vision, hearing, speech, language, mobility, etc.)
3. Describe any specific care instruction regarding 1) and/or 2) above.

OTHER HEALTH CARE PROFESSIONALS INVOLVED IN YOUR CHILD'S LIFE *(e.g. occupational therapist / physical therapist)*

ANY OTHER INFORMATION I SHOULD KNOW

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 *(Facility has provided a copy of the following)*

1. Prepayment policy Yes ☐ No ☐
2. Behavioural Guidance Yes ☐ No ☐

ADDITIONAL INFORMATION ABOUT YOUR CHILD (OPTIONAL)

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 DESCIBE THE GUIDANCE AND DISCIPLINE METHODS USED AT HOME.

PRIMARY LANGUAGE SPOKEN IN THE HOME	OTHER LANGUAGES
NAME OF ENGLISH SPEAKING PERSON (IFF NEEDED)	TELEPHONE

EATING AND NUTRITION

LIST YOUR CHILD'S FAVOURITE FOOD

LIST ANY DISLIKED FOOD.

PLEASE DESCIBE ANY PARTICULAR EATING PATTERNS.

ARE THERE ANY RELIGIOUS OR ETHNIC OBSERVANCES RELATED TO FOODS?

SLEEPING

NAP TIME	HOW LONG TO SETTLE	TIME OF WAKING
BEDTIME	HOW LONG TO SETTLE	TIME OF WAKING

DOES YOUR CHILD TAKE A FAVOURITE COMFORTER (E.G. BLANKET OR TOY) TO BED?

Yes ☐ No ☐ IF YES, DESCRIBE AND TELL US IF IT IS "NAMED".

WHAT IS YOUR CHILD'S MOOD UPON WAKENING?

TOILETING

IS YOUR CHILD TOILET TRAINED?

Yes ☐ No ☐ PARTIALLY ☐

PLEASE INDICATE YOUR CHILD'S FREQUENCY OR PATTERNS FOR BOWEL MOVEMENTS.

DESCRIBE ASSISTANCE NEEDED FOR TOILETING.

WHAT "SPECIAL" WORD DOES YOUR CHILD USE FOR? URINATION: _____ BOWEL MOVEMENTS: _____

CHILD IMMUNIZATION STATUS DECLARATION

Community Care Facilities (that are licensed to provide care to children are required to have a copy of the Immunization Status on file for each child in care, in the event that an outbreak of a communicable disease should occur. This information will assist in identifying those that may require exclusion because they are not immunized.

This form has been provided to:

- Assist in identifying those children who are not fully immunized and
- Assist licensee's in meeting Section 21(1)(a) of the *Child Care Licensing Regulation.*

To be completed by Parent/Guardian:

_____ _____

Child's Name Date of Birth

Complete Immunization:

☐ Record on vaccinations attached

☐ Record on vaccinations unavailable

Received immunization in:

_____ _____ _____ _____

Year of last Vaccine City Province (if not in Canada, include country)

Incomplete Immunization:

☐ My child has had some vaccinations

☐ My child has no vaccinations

☐ I do not know

_____ _____

Parent's/Guardian's Printed Name Date

_____

Parent's/Guardian's Signatures

CHILD CARE

CCFL3, Rev 04-2009

EMERGENCY CONSENT FORM

Please attach child's photo to this form.

CHILD'S NAME: _____ BIRTHDATE: _____
SURNAME FIRST NAME(S) YEAR/MONTH/DAY

ADDRESS: _____

PARENT'S NAME: _____ HOME PHONE: _____

CELL PHONE: _____ WORK PHONE: _____

PARENT'S NAME: _____ HOME PHONE: _____

CELL PHONE: _____ WORK PHONE:_____

EMERGENCY CONTACT: _____ CELL PHONE: _____ PHONE: _____

OUT OF TOWN CONTACT: _____ PHONE: _____

CHILD'S DOCTOR: _____ PHONE: _____

DATE OF MOST RECENT TETANUS SHOT:_____

ALLERGIES / MEDICATIONS: _____

CHILD'S DENTIST: _____ PHONE: _____

CARE CARD NUMBER_____

CONSENT

1) It is the policy of this facility to notify a parent when a child is ill or needs medical attention. Occasionally we cannot contact parents and we need to get immediate help for the child. Our procedure is to call for an ambulance.

2) Please sign the consent below so that we can take the appropriate action on behalf of your child. Return the signed consent to the facility immediately. We will take this consent with us to the emergency centre.

3) I hereby give consent for my child _____ to be taken to the nearest emergency centre when I cannot be contacted.

4) I hereby give consent for my child named above to receive medical treatment.

_____ _____
DATE SIGNATURE OF PARENT / GUARDIAN

_____
WITNESS

Parent Handbook Agreement Form

Creative Path Daycare

I have read clearly and understand the Parent Handbook of 'Creative Path Daycare' and agree to abide by the policies and procedures contained within. I understand that not adhering to the 'Creative Path Daycare' policies and procedures may result in service being withdrawn.

Child's Name _____

Parent's Signature_____**Date**_____

Parent's Signature_____**Date**_____

All parents or guardians must sign the policy.

Photo Consent Form

Creative Path Daycare
6579 133 Street
Street, BC V3W 8E1
Ph: 778-707-6579

Dear Parents,

From time to time, we have activities that we would like to take some photos of. We would like to share these photos on our website and WhatsApp group and/or Facebook page. We ask you please sign below to provide us with your permission to take and post photos of your child/children.

I, parent and/or guardian of: _____,
Give permission to the staff of Creative Path Daycare, to take pictures of my child/children during activities and to post those pictures on the daycare's website and WhatsApp group and/or Facebook page.

Signature: _____

Name: _____

Date signed: _____

Witness signature: _____

Thank you!