

Registration Date _____ Start Date _____

Child's Name		First	Last	Male <input type="checkbox"/>		Female <input type="checkbox"/>	
Date of Birth		Medicare #		Expiry Date			
Address		Street	Apt #	City/Town		Prov	Postal Code
Parent/Guardian Name			Email Address		Home Telephone Number		
Address		Street	Apt #	City/Town		Prov	Postal Code
(if different from child's)							
Place of Work			Work Telephone Number		Cell Telephone Number		
Parent/Guardian Name			Email Address		Home Telephone Number		
Address		Street	Apt #	City/Town		Prov	Postal Code
(if different from child's)							
Place of Work			Work Telephone Number		Cell Telephone Number		
Child's Living Arrangement							
Other than you, who has permission to pick up your child?							
Name		Relationship		Address		Daytime Telephone Number	

If changing pick up arrangements parents must inform the facility prior to the child being picked up.

For centre office use only:			Checker – please initial in the applicable box to verify item is present								
Child Name	Address	D.O.B.	Medicare	Expiry	Doctor Name	Address	Phone	Parent Name(s)	Contact #	Contact #	E Contact Info 1
E Contact Info 2	Health History Immunization Rec	Infant Routine	Family Handbook	Inclusion Policy	Allergies	Photo Video	Sleep >2 hrs	Emergency Care	Field Trips	Acetaminophen	Authorized Pick-Up

Is there anyone who does not have permission to pick up your child?			
Name			
Name			
Name			

Appropriate paperwork such as custody papers must be attached if a parent is not permitted to have contact with the child. Please discuss with the operator/administrator.

Two emergency contacts (other than parents/guardians) Must be able to respond within one hour if parent(s)/guardian(s) cannot be reached			
Name	Relationship	Address	Daytime Telephone Number

Child's health record

<p><u>ALLERGY ALERT:</u> Please list any serious allergies</p> <p>_____</p> <p>_____</p>
<p>Are any of the above allergies severe enough to require Epipen, medications, or emergency treatment? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please complete an Allergy Management and Emergency Plan available from the operator.</p> <p>Please list any food, medication or contact allergies (non-life threatening)</p> <p>_____</p>
<p>Does your child require any essential routine services on a regular basis as part of a daily routine such as, catheterization, special hygiene procedures, on-going administration of medication, or ongoing observation of certain health conditions, such as diabetes, to determine when intervention is needed? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please complete an Essential Routine Services and Emergency Plan available from the operator.</p> <p>Name of Medical Practitioner _____</p> <p>Telephone Number _____</p> <p>Address _____</p>

Medical History: Please indicate if your child has had any of the following:					
	Yes	No		Yes	No
Measles			Rubella		
Mumps			Chicken Pox		
Meningitis			Pertussis (Whooping Cough)		
Health Status: Indicate if your child has any of the following:					
	Yes	No		Yes	No
Asthma			Diabetes		
Eczema/Psoriasis			Epilepsy/Seizures		
Other:			Other:		
Ongoing Medical Treatment: Please indicate any ongoing medical treatment your child may need (you will be required to complete an Administration of Medication form)					
Name of medication			Dosage		
Condition being treated					
Name of medication			Dosage		
Condition being treated					
Immunizations: In accordance with subsection 12(2) of the <i>Reporting and Diseases Regulation - Public Health Act</i> , proof of immunization must be provided for each child attending an early learning and childcare facility for the following:					
diphtheria	rubella	mumps			
tetanus	varicella	measles			
polio	meningococcal disease	Haemophilus influenza type B			
pertussis	pneumococcal disease				
Where proof is not provided you must have the following waivers:					
<ul style="list-style-type: none"> - a medical exemption, on a form provided by the Minister of Health, that is signed by a medical practitioner or nurse practitioner, or - a written statement, on a form provided by the Minister of Health, signed by the parent or legal guardian of his or her objections to the immunizations required by the Minister. 					
Note: Public Health will periodically review child files to ensure immunizations are complete or waivers are present.					
Are there any activities in which your child cannot medically participate?					
Please list any dietary restrictions (including those for medical, cultural, religious reasons):					

Please advise the operator/administrator immediately of any changes to your child's health.

Preschool/childcare history

Has your child attended preschool/childcare before? Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, for how long? 6 months <input type="checkbox"/> 1 year <input type="checkbox"/> 2 years <input type="checkbox"/> more than 2 years <input type="checkbox"/>
If yes, please describe your child's experience:

Child development

Self Help: Does your child need help with the following? If yes, in what way?	
Dressing/Undressing:	
Eating:	
Toileting:	
Handwashing/Toothbrushing:	
Other: (ie: gross and/or fine motor skills)	
Are there any hints/suggestions that will make your child's transition to the facility a positive one?	
Tell us a few things about your child	
What does your child like to do? (i.e.: look at books, listen to music, play with other children, play outdoors/indoors, toys, climb/run/jump, paint, computer, imaginative play/dress-up)	
Is there anything else you would like to share with us about your child?	
Parent/Guardian Signature	Date
Parent/Guardian Signature	Date

**Information on this form is to be verified for accuracy annually.
Please immediately advise the operator/administrator of any changes.**