APPLE BLOSSOM CHILD CARE CENTRE

Registration FORM (PLEASE PRINT)

Start Date: _________________________ Monthly Fee: ________________________

Days attending: ______________________________

*Please note that all information will be kept confidential. In order to give the best care possible, the teachers need to have a clear picture of your child. Thank you for your assistance in completing the following questions.

CHILD'S NAME_______________________________ SEX: M / F

ADDRESSS: ________________________________ POSTAL CODE: ____________________

BIRTHDATE: _______________________ PHONE NUMBER: _________________________

PARENT/MOTHER/GUARDIAN: ____

PHONE: ____

ADDRESS: ______________________________________ POSTAL CODE: _____________________

EMPLOYER: ___________________________________ PHONE: ___________________________

HOURS YOU CAN BE REACHED: ____

PARENT/FATHER/GUARDIAN: ____

PHONE: ____________________________

ADDRESS: _______________________________________ POSTAL CODE: ____________________

EMPLOYER: ________________________________ PHONE: ____________________________

HOURS YOU CAN BE REACHED: _______________________________________

EMERGENCY CONTACT: ___________________________ PHONE: __________________________

EMERGENCY CONTACT: ___________________________ PHONE: __________________________

EMERGENCY CONTACT: ___________________________ PHONE: __________________________

THE FOLLOWING INFORMATION IS REQUIRED FOR THE SAFETY AND WELL-BEING OF YOUR CHILD: WE URGE YOU TO KEEP IT CURRENT: I AUTHORIZE THE FOLLOWING PEOOPLE TO PICK UP MY CHILD:

NAME: ____________________________________ PHONE: ____________________________

NAME: ____________________________________ PHONE: ____________________________

NAME: ____________________________________ PHONE: ____________________________

NAME: ____________________________________ PHONE: ____________________________

I understand that the staff cannot release my child to any persons not listed above and I must notify staff of changes in the above list.

FAMILY IFORMATION:

PLEASE LIST SIBLINGS

NAME: ___________________________________ AGE: ________________________

NAME: ___________________________________ AGE: ________________________

NAME: ___________________________________ AGE: ________________________

Language Spoken at home: ____

YOU'RE CHILD LIVES WITH: ____

(Include any other significant adults or children living with your family)

Is there any specific custody arrangements? (If yes please describe) ___________________

____

____

Is there any imminent danger to your child or a chance of future harm? (If yes please describe)

____

PLEASE DESCRIBE YOUR CHILD:

Hair Colour: ___________________________ Eye Colour: ___________________________

Approximate Weight: _____________________ Approximate Height: __________________

Have you applied for subsidy? Yes / No

Has your child attend another childcare program: Yes / No

Do you follow any religious or ethnic observances?

____

HEALTH HISTORY:

CHILD'D DOCTOR: ________________________ PHONE: ___________________________

CHILD'S CARE CARD NUMBER: ____

Does your child have any allergies?

____

____

____

Does your child require any regular medication?

____

____

What happens if your child does not receive said medication? Please describe

____

____

Has your child received any service from the public health nurse? YES / NO

Hearing: Does your child experience frequent (2 or more) ear infection? YES / NO

Does your child have a diagnosed hearing loss? YES / NO

Are you aware of any vision or hearing problem? YES / NO

Have you ever been concerned about your child's speech or

Language development? YES / NO

Does your child have any condition that may require emergency care? YES / NO

Please describe:

____

Please indicate any other special concerns, illnesses, allergies, operations, medications or chronic conditions etc.:

____

____

Do you agree to allow the public health nurse to examine your child for vision, hearing and general health concerns during any visits to the centre? YES / NO

Are there any concerns of abuse or neglect? _____________________________________

____

Has your child been in the care of the Ministry of Children and Families? _____________

____

Is there a social worker involved? ____

____

Are there any health concern? (Physical, cognitive, emotional or environment)

____

Is there any other information that we should know regarding your child to better serve them?

____

____

SLEEPING:

SLEEPING PROCEDURES: ____

____

Does your child use a soother? YES / NO

TOILETTING:

Does your child use diaper? YES / NO

Does your child sit on the potty? YES / NO

Is there any special words that your child uses to tell you when he/she needs to use the bathroom or when their diaper is soiled? If yes what are they?

____

____

INTERESTS:

Does your child have favorite toys, activities and songs?

____

____

___________________________________ ______________________________

Signature of Parent / Guardian Date