



ST.ANN'S PARISH DAYCARE CENTER

33333 Mayfair Avenue, Abbotsford, B.C. V2S 1P4 PH:604-852-5602 / 604-300-8661

REGISTRATION FORMS FOR CHILD CARE

FACILITY NAME:	
FULL NAME OF CHILD:	USUAL NAME OF CHILD <i>(if different)</i> :

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 childcare center 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:	



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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:
PERSON(S) NOT AUTHORIZED TO PICK UP CHILD		
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

CUSTODY AGREEMENT:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
IF YES, SUPPLY A COPY OF THE CUSTODY ORDER TO THE FACILITY MANAGER / LICENSEE		

ALTERNATIVE 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 a copy of immunization)					
IS YOUR CHILD IMMUNIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO					
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:					



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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. ,behavior, 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?



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ADDITIONAL CHILD HISTORY

(OPTIONAL)

EATING AND NUTRITION		
LIST YOUR CHILD'S FAVOURITE FOOD:		
LIST ANY DISLIKED FOOD:		
PLEASE DESCRIBE ANY PARTICULAR EATING PATTERNS:		
ARE THERE ANY RELIGIOUS OR ETHIC OBSERVANCES RELATED TO FOODS:		
SLEEPING		
NAP TIME:	HOW LONG TO SETTLE	TIME OF WAKING:
BED TIME:	HOW LONG TO SETTLE	TIME OF WAKING:
IS YOUR CHILD A DEEP SLEEPER, OR DOES (S) HE AWAKEN EASILY?		
DOES YOUR CHILD TAKE A FAVOURITE COMFORTER [E.G. BLANKET OR TOY] TO BED?		
IF YES, PLEASE DESCRIBE AND TELL US IF ITS "NAMED" <input type="checkbox"/> YES <input type="checkbox"/> NO		
WHAT IS YOUR CHILD'S MOOD UPON WAKENING?		
TOILETING		
IS YOUR CHILD TOILET -TRAINED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 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 _____



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PARENT CONTRACT

- I have read the information on St. Ann’s Daycare and understand what I have read. I have spoken to St. Ann’s Daycare staff to clarify anything I was unsure of.
- I realize that I am paying for all statutory holidays plus 2 weeks of holiday time each year
- The statutory holidays are as listed: **New Year’s Day, BC Family Day, Good Friday, Easter Monday, Victoria Day, Canada Day, BC Day, Labor Day, September 30 - National Day for Truth and Reconciliation, Thanksgiving Day, Remembrance Day, Christmas Day and Boxing Day.**
- The holiday time each year will be the 2nd and 3rd week of July. These closure days will be posted earlier enough so you can plan your holidays or find alternate care for your children.
- I understand the sick policy and will not send my child to daycare if they are ill. I will wait 24 hours after my child’s last symptoms before bringing my child back to daycare.
- I understand the late pick up policy and agree to pay the late fees if for any reason I pick up after 6:00p.m. Late pick up is \$1 a minute and paid directly to the staff member who remains at the center late with your child.
- I realize all fees are due and payable on the 1st of each month and failure to pay on time results in my child being unable to attend until fees are paid in full. Failure to pay can mean possible loss of daycare space at St. Ann’s Daycare. I also realize that my daycare fees are non refundable and if I no longer need St. Ann’s Daycare services I need to give 30 days’ written notice. There will be no money refunded.
- I will submit my child’s Emergency Kit to St. Ann’s Daycare staff within the first week my child attends.
- I acknowledge that daycare fees are still payable if my child is sick, on vacation or absent for any reason. Daycare fees are also payable on all statutory holidays and snow days.
- I will drop off and pick up at the scheduled time each day so my child and staff know when I am coming and I will give staff notice if for some reason my child will be dropped off or picked up at a different time than usual.
- St. Ann’s Daycare Center has the right to dismiss a child from care without notice. This would be done only in matters of safety for daycare staff and children.
- I will make sure to notify St. Ann’s Daycare Center before 9am if my child will be absent for any reason.
- If you are a teacher or do seasonal work, you still have to maintain your daycare fees during your time off. If you decide to let your space go, you will need to give us 30 days written notice and your spot is not guaranteed to be there if you need to return. We cannot hold spots without payment.

Signed _____

St. Ann’s daycare Staff _____



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ADMINISTRATION OF MEDICATION CONSENT FORM

CHILD'S NAME:	
PHYSICIAN'S NAME:	PHONE:
PHARMACY NAME:	PHONE:
MEDICATION:	PRESCRIPTION #:
DOSAGE OF MEDICATION:	HAS THIS MEDICATION BEEN ADMINISTERED TO THIS CHILD PREVIOUSLY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF NO, HAS CHILD RECEIVED MEDICATION FOR 24HRS PRIOR TO RETURNING TO THE CHILD CARE PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO
TIME TO BE GIVEN BY PARENT:	
TIMES TO BE GIVEN BY A CARE PROVIDER:	
ANY POSSIBLE SIDE EFFECTS THAT YOU HAVE BEEN MADE AWARE OF BY THE PHYSICIAN OR PHARMACY?	

I hereby give permission and authorize _____ to administer the medication in the dosage as stated above. This dosage is consistent with the recommendations of the physician and /or drug manufacture. I accept the responsibility of supplying the current correct medication in its original container, and I agree to submit a new consent form if there is any change in the medication to be administered.

Signature of Parent/ Guardian _____ Date _____ Phone _____

CAREGIVER'S ADMINISTRATION RECORD:

DATE:	TIME GIVEN:	AMOUNT GIVEN:	ADMINISTERED BY:



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