



PICS CHILDCARE
6050 - 176 Street, Cloverdale
PHONE: 604-596-7722
FAX: 604-596-7721

REGISTRATION FORM

Registration Date: _____ Start Date: _____

CHILD'S INFORMATION:

Child's Name: _____ Sex: Female Male

Birth date: _____ Place of Birth: _____

Days

Required: Mon Tues Wed Thurs Fri

Program: Full days Half Days (max 4 hrs/day)

PARENT/GUARDIAN INFORMATION:

MOTHER'S INFORMATION	FATHER'S INFORMATION
Name:	Name:
Address:	Address:
Primarily Phone:	Primarily Phone:
Alternate Phone:	Alternate Phone:
Work Place:	Work Place:
Work Phone:	Work Phone:

Marital Status: Married/Common Law Separated Single Divorced

If parents are separated or divorced you must provide a copy of any legal documentation.

Additional Information:

Siblings (name & age)

EMERGENCY CONTACTS/AUTHORIZED PICK UP:

If, by any chance, you are unable to pick up your child, or in case of an emergency, we are unable to contact you directly, please fill out the required information for other people we can contact or release your child to. (Note: for an emergency contact ONLY, it may be a family member(s) or friend(s) who live out of town.)

Contact #1		
Name: _____		
Primarily Phone: _____	Alternate Phone: _____	Alternate Phone: _____
Relationship to Child: _____		
Check ALL that are relevant:	<input type="checkbox"/> Emergency Contact	<input type="checkbox"/> Authorized Pick Up
Comment: _____		

Contact #2		
Name: _____		
Primarily Phone: _____	Alternate Phone: _____	Alternate Phone: _____
Relationship to Child: _____		
Check ALL that are relevant:	<input type="checkbox"/> Emergency Contact	<input type="checkbox"/> Authorized Pick Up
Comment: _____		

Contact #3 (Out of Province Contact for natural disaster)		
Name: _____		
Primarily Phone: _____	Alternate Phone: _____	Alternate Phone: _____
Relationship to Child: _____		
Check ALL that are relevant:	<input type="checkbox"/> Emergency Contact	<input type="checkbox"/> Authorized Pick Up
Comment: _____		

HEALTH & MEDICAL INFORMATION:

Child's Care Card No.: _____ Ambulance Permission: Yes No

Doctor's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

Allergy/Medical Condition Of Child	Exposure to Eating? Touching? Smelling?	Is This a Life Threatening Allergy?	Symptoms of the Allergic Reaction	Medication/Treatment Required	Follow-up Procedure

Special Food Requirements (if any):

I give permission to the staff of PICS Childcare to administer the medication stated above in an emergency situation.

Date:

Signature:

Please check any your child has/had:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Croup | <input type="checkbox"/> Measles | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Pink Eye | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Eye Infection |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Ear Tubes | <input type="checkbox"/> Ear Infection |
| <input type="checkbox"/> Bowel Disorders | <input type="checkbox"/> Respiratory Problems | Other: _____ | |

IMMUNIZATION

Please sign below if your child is immunized and will continue to be immunized as required. Please bring us a photocopy of your child's immunization records. Should there be an outbreak of a communicable disease in the daycare, your child will NOT be able to attend, unless this copy has been signed and provided.

Parent Signature: _____ **Date:** _____

CONSENT FORMS:

1) Emergency

I give permission for my child, in case of emergency to receive medical procedures deemed necessary by my physician, or any other physician, selected by the Facility. I understand that this will only happen after all attempts have been made to contact the parents and/or guardians as listed in the registration forms at the Facility.

Date:

Signature:

2) Field Trips/Neighborhood Walks

I give permission for my child to be transported on field trips using the facilities vehicles. I understand that this may also include walking on foot, with staff vehicles or public transportation. I also give permission for neighborhood walks.

Date:

Signature:

3) Medicine

I will make every attempt to administer medication at home. In the event that the time requires that my child must take it during Facility hours, the following will occur: the prescription medication will be provided to a staff person in the original container with the prescription legible, indicating the date, the doctor's name, the dosage and the directions. I will sign a further, detailed medicine consent form at that time.

Date:

Signature:

4) Photos

I give permission for the Facility staff and families to take pictures/videos of my child, during daycare activities and special events that may occur at the centre.

Date:

Signature:

5) Sunscreen

On the occasion that I am unable to provide sunscreen for my child, I hereby authorize the Facility to apply SUNSCREEN SPF 30+ on my child during the season when children are at risk from the sun.

Date:

Signature:

6) Withdrawal

I am aware that I **MUST** provide the Facility with a **minimum one month WRITTEN notice** before withdrawing my child(ren). **Notice must be received no later than the last working day of the previous month.** If I fail to do so, my deposit will **not be returned.**

Date:

Signature:

Any additional information you would like to provide:
