PICS CHILD CARE CENTRE

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:	☐ Emergency Contact	☐ Authorized Pick Up	
Comment:			

Contact #2			
Name:			
Primarily Phone:	Alternate Phone:	Alternate Phone:	
Relationship to Child:			
Check **ALL** that are relevant:	☐ Emergency Contact	☐ 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:	☐ Emergency Contact	☐ 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:

☐ Chicken Pox	☐ Croup	☐ Measles	☐ Pneumonia
☐ Mumps	☐ Asthma	☐ Diabetes	☐ Scarlet Fever
☐ Rheumatic Fever	☐ Epilepsy	☐ Bronchitis	☐ Eczema
☐ Whooping Cough	☐ Pink Eye	☐ Heart Condition	☐ Eye Infection
☐ Vision problems	☐ Hearing Problems	☐ Ear Tubes	☐ Ear Infection
☐ Bowel Disorders	☐ 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:

_____

_____