FRANKLAND DAY CARE CENTRE
SUMMER REGISTRATION FORM

Child's Name: _____

Parents/ Child's Full Address: _____
(Street & Number) (City) (Province) (Postal code)

Home Phone Number: _____ **Date of Birth (M/D/Y):** _____/_____/_____
(Month) (Day) (Year)

E-mail Address_____

Child's Doctor, Address, Phone#: _____
(Name)

_____
(Street & Number) (City) (Province) (Postal code)

1. Parent Name: _____

Address: _____
(Street & Number) (City) (Province) (Postal code)

Home Phone Number: _____ **Cell Phone:** _____

Employer: _____ **Business Phone:** _____

2. Parent Name: _____

Address: _____
(Street & Number) (City) (Province) (Postal code)

Home Phone Number: _____ **Cell Phone:** _____

Employer: _____ **Business Phone:** _____

3. Parent Name: _____

Address: _____
(Street & Number) (City) (Province) (Postal code)

Home Phone Number: _____ **Cell Phone:** _____

Employer: _____ **Business Phone:** _____

4. Parent Name: _____

Address: _____
(Street & Number) (City) (Province) (Postal code)

Home Phone Number: _____ **Cell Phone:** _____

Employer: _____ **Business Phone:** _____

****EMERGENCY CONTACT - (Other than a Parent/ Guardian)****

Name: _____

Address: _____
(Street & Number) (City) (Province) (Postal Code)

Home Phone Number: _____ **Business Phone:** _____

Relationship to child: _____

CHILD'S HEALTH HISTORY

Please list any past communicable diseases (i.e. Chicken pox, Mumps, German Measles, etc.) and/or illnesses (i.e. asthma, bronchitis, epilepsy) which your child has contracted that the day care should know about.

Type of Communicable Disease and/or Illness	**Has Contracted**	**Has Not Contracted**	**Month and Year (if possible)**
Chickenpox			
German Measles			
Mumps			
Scarlet Fever			
Tonsillitis			
Bronchitis			
Pneumonia			
Epilepsy			
Asthma			

Does your child have frequent colds _____ tonsillitis _____ earaches _____
Stomach aches _____ high fever _____

Are there any ongoing health concerns you feel the staff should know about in order to best help your child? _____
_____

Please describe any symptoms that would indicate that your child is of ill health. _____
_____
_____

ALLERGIES

Please list all allergies including life threatening (anaphylactic) allergies.

Type of Allergy: _____
_____

Signs & Symptoms specific to your child of an anaphylactic reaction: _____
_____
_____
_____

Action to be taken by day care staff should your child have an anaphylactic/allergic reaction:
_____
_____
_____

Are there any food restrictions due to religious beliefs and/or allergies? Please list_____
_____
_____

MEDICAL EMERGENCY CONSENT

While every possible effort will be made to reach parents in the event of a medical emergency, we request permission to authorize a doctor to give necessary treatment in the event of such an emergency.

Parent Consent: I agree to medical treatment being given to this child if at any time such treatment is necessary because of circumstances such as accident, sudden illness, or emergency.

_____ _____

Parent Signature Date

MISCELLANEOUS INFORMATION

What food likes and dislikes does your child have? _____

_____

_____

Please list any information that you believe will be of benefit in providing quality care to your child. (For example, dietary, rest and/or exercise requirements)

_____

_____

_____

_____

_____

_____ _____

Parent Signature **Date**