FRANKLAND DAY CARE CENTRE
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)

Preferred Start Date: ______/______/______ **E-mail Address**____________________________
(Month) (Day) (Year)

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

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

Parent Name: ____

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

Home Phone Number: ______________________ **Cell Phone:** ______________________

Employer: ____________________________ **Business Phone:** ____________________

Parent Name: ____

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

Home Phone Number: ______________________ **Cell Phone:** ______________________

Employer: ____________________________ **Business Phone:** ____________________

Parent Name: ____

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

Home Phone Number: ______________________ **Cell Phone:** ______________________

Employer: ____________________________ **Business Phone:** ____________________

Parent Name: ____

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

Home Phone Number: ______________________ **Cell Phone:** ______________________

Employer: ____________________________ **Business Phone:** ____________________

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: _____
_____
_____
_____

ALLERGIES CONTINUED…

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)

_____
_____
_____
_____
_____

WAITING LIST POLICY

IT IS THE CENTRE POLICY TO PLACE SIBLINGS OF CHILDREN WHO ARE CURRENTLY ENROLLED IN THE CENTRE AT THE FRONT OF THE WAIT LIST FOR THEIR AGE GROUP.

ONCE A FAMILY RECEIVES AN OFFER FOR A FULL TIME IN DISTRICT CHILD CARE SPACE THE CENTRE WILL REQUIRE THE PARENT/GUARDIAN TO PROVIDE (2) TWO PIECES OF IDENTIFICATION THAT SHOW PROOF THE ADDRESS IS IN DISTRICT FOR FRANKLAND COMMUNITY SCHOOL. THESE PIECES OF IDENTIFICATION WILL NEED TO BE PRODUCED WITHIN (5) FIVE BUSINESS DAYS AFTER THE OFFER. A COPY WILL BE KEPT IN YOUR CHILD'S CONFIDENTIAL FILE. IDENTIFICATION MAY INCLUDE BUT IS NOT LIMITED TO, TELEPHONE BILL, VALID DRIVER'S LICENCE, UTILITY BILL, OR LEASE AGREEMENT. WRITTEN CONFIRMATION OF THE OFFERED SPACE WILL NOT BE PROVIDED BY THE CENTRE SUPERVISOR UNTIL THE (2) TWO PIECES OF IDENTIFICATION HAVE BEEN SEEN AND COPIED.

Date of Registration: _____ Start Date: _____

Date of Discharge: _____ Parent Signature: _____