YUS Montessori School

REGISTRATION FORM FOR CHILD CARE ☐ Full Day ☐ AM ☐ PM

FACILITY NAME: YUS Montessori School	
FULL NAME OF CHILD:	USUAL NAME OF CHILD (IF DIFFERENT):

PERSONAL INFORMAION		
CHILD'S DATE OF BIRTH:	GENDER:	STARTING DATE:
ADDRESS (**include post code**) :		E-MAIL: PHONE:
PARENT OR GUARDIAN:**(Mother)**		PARENT OR GUARDIAN:**(Father)**
ADDRESS (IF DIFFERENT THAN ABOVE):		ADDRESS (IF DIFFERENT THAN ABOVE):
CELLULAR PHONE:		CELLULAR PHONE:
WORK ADDRESS / ALTERNATE LOCATION:		WORK ADDRESS / ALTERNATE LOCATION:
WORK PHONE (INCLUDE AREA CODE):		WORK PHONE (INCLUDE AREA CODE):
HOURS AT THIS LOCATION:		HOURS AT THIS LOCATION:

EMERGENCY HEALTH INFORMATION			
CARE CARD NUMBER:			
FAMILY DOCTOR / CLINIC NAME:		FAMILY DOCTOR / CLINIC NAME:	
ADDRESS:	PHONE:	ADDRESS:	PHONE:

CONSENT FOR EMERGENCY CARE	
I authorize the staff at the child care centre 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:	

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):

1. Please describe any concerns / issues regarding your child's health (seizures, asthma, vision, hearing, etc.)

2. Please describe any concerns you may have regarding your child's development (i.e., behaviour, vision, speech, language, mobility, etc.,):

3. Describe any specific care instruction regarding 1 and/or 2:

OTHER HEALTH CARE PROFESSIONALS INVOLVED IN YOUR CHILD'S LIFE, E.G., OCCUPATIONAL THERAPIST/PHYSICAL THERAPIST:

GROUP EXPERIENCES

WHAT IS/ARE YOUR CHILD'S FAVORITE 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?

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 YOUR CHILD		
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

ALTERNATE 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 copy of immunization)

IS YOUR CHILD IMMUNIZED? ___ YES ___ 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.		

NOTE:

FAMILY AND GENERAL HOUSEHOLD INFORMATION	
PARENTS LIST THE NAMES OF THE SIGNIFICANT PEOPLE IN YOUR CHILD'S LIFE (E.G., SIBLINGS, GRANDPARENTS, ETC.):	
PLEASE DESCRIBE THE GUIDANCE AND DISCIPLINE METHODS USED AT HOME:	
PRIMARY LANGUAGE SPOKEN AT HOME:	OTHER LANGUAGES:
NAME OF ENGLISH SPEAKING PERSON (IF NEEDED):	PHONE:

ANY OTHER COMMENTS

SIGNATURE OF PARENT OR GUARDIAN PROVIDING INFORMATION		
SIGNATURE:	PRINT NAME:	DATE:

NOTE: This information may be reviewed by Fraser Health Authority Licensing staff as per legislation.

FACILITY USE ONLY		
Staff person reviewing family's documents:		
SIGNATURE:	PRINT NAME:	DATE:
CHILD'S WITHDRAWAL DATE:	REASON FOR WITHDRAWAL:	