CHILD CARE FACILITIES REGISTRATION FORM

CHILD'S STARTING DATE: _____/_____/_____
YEAR MONTH DATE

DATE OF BIRTH: _____/_____/_____
YEAR MONTH DATE

SEX: M___F___

NAME OF CHILD: _____
(SURNAME) (GIVEN NAME) (ALSO KNOWN AS)

NAME CHILD RESPONDS TO: _____

ADDRESS: _____

POSTAL CODE: _____ PHONE: _____

PERSON(S) WITH WHOM CHILD LIVES (ADULTS & CHILDREN): _____

_____

CHILD'S FIRST LANGUAGE: _____ SECOND LANGUAGE: _____

PARENT(S)/GUARDIAN(S):

NAME: _____ HOME PHONE: _____

WORK PHONE: _____ LOCAL: _____ DAY/HOURS OF WORK: _____

NAME: _____ HOME PHONE: _____

WORK PHONE: _____ LOCAL: _____ DAY/HOURS OF WORK: _____

PERSON(S) AUTHORIZED TO PICK UP CHILD AND/OR BE CONTACTED IN CASE OF EMERGENCY (INCLUDE MOTHER/FATHER/GUARDIAN):

NAME: _____ RELATIONSHIP TO CHILD: _____

HOME PHONE: _____ WORK PHONE: _____

NAME: _____ RELATIONSHIP TO CHILD: _____

HOME PHONE: _____ WORK PHONE: _____

NAME: _____ RELATIONSHIP TO CHILD: _____

HOME PHONE: _____ WORK PHONE: _____

NAME: _____ RELATIONSHIP TO CHILD: _____

HOME PHONE: _____ WORK PHONE: _____

IF APPROPRIATE, ENGLISH SPEAKING CONTACT:

NAME: _____ PHONE: _____

IF THERE IS A CUSTODY AGREEMENT, PLEASE GIVE DETAILS AND ATTACH COPY:

_____

_____

HAS CHILD PREVIOUSLY ATTENDED DAYCARE/PRESCHOOL?

YES_____ NO _____ IF YES, WHERE? _____

COMMENTS/INSTRUCTIONS TO HELP US CARE FOR YOUR CHILD:

TOILETING/DIAPERING:_____

REST TIME_____

EATING/MEALTIME_____

FEARS_____

HEALTH INFORMATION

FAMILY DOCTOR:_____ PHONE: _____

FAMILY DENTIST:_____ PHONE: _____

OTHER HEALTH PROFESSIONALS INVOLVED WITH YOUR CHILD:

_____ PHONE: _____

_____ PHONE: _____

_____ PHONE: _____

CARECARE PERSONAL HEALTH NUMBER:

_____

DATE EFFECTIVE:

_____/_____/_____
YEAR MONTH DATE

IF APPROPRIATE, COMMENT ON THE FOLLOWING HEALTH ISSUES:

SPECIAL MEDICATIONS:_____ VISION OR HEARING:_____ ALLERGIES:_____

SPEECH OR LANGUAGE:_____ OTHER:_____

_____

_____

PARENTS' COMMENTS (IF ANY):

_____

_____

This health information is to be made available to the staff of the Vancouver Health Department.

I give my consent for my child to be involved in drop-in visits by the Vancouver Health Department staff.

SIGNATURE OF PERSON PROVIDING INFORMATION:_____

SIGNATURE OF PERSON RECEIVING INFORMATION:_____

DATE:_____/_____/_____
YEAR MONTH DATE