

**Everyday Sunshine Child Care**

**6226 175B St Surrey, BC V3S 0P9**

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| **REGISTRATION FORM FOR CHILD CARE**FACILITY NAME: - |
| CHILD FULL NAME: - |
| USUSAL NAME OF CHILS (OR DIFFERENT):-  |

* ***PERSONAL INFORMATION***

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| --- | --- |
| CHILD DATE OF BIRTH: -  | GENDER: - |
| ADDRESS: -  | POSTAL CODE: - |
| PHONE 1:-  | PHONE 2 :- |
| WORK ADDRESS: -  | WORK PHONE: - |
| STARTING DATE: -  |
| HOURS :-  | TIMINGS :-  |

* ***EMERGENCY HEALTH INFORMATION***

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| CARE CARD NUMBER: -  |
| FAMILY DOCTOR/CLINIC NAME: - | FAMILY DENTIST CLININC NAME:- |
| ADDRESS: -  | ADDRESS: -  |
| PHONE: -  | PHONE: -  |

* ***CONSENT FOR EMERGENCY***

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| I AUTHORISE THE STAFF OF CHILD ACRE CENTRE TO CALL A MEDICAL PRACTINIOR OR AMBULANCVE IN THE CASE OF EMERGENCY, ACCIDENT OR ILLLNESS OF MY CHILD(REN), IF THE PARENT CANNOT IMMEDIATELY BE REACHED. |
| PARENT/GUARDIN SIGN :-  | DATE :-  |
| MANAGER OF FACILITY :-  |  |

* ***PERSON(S) AUTHORISED FOR PICKING OR DROPPING***

**(other than parent/guardian)**

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| --- | --- | --- |
| Name: -  | Relationship:-  | Phone :-  |
| Name: -  | Relationship:-  | Phone :-  |
| Name: -  | Relationship :-  | Phone :-  |
| Name: -  | Relationship :-  | Phone :-  |
| Name:-  | Relationship :-  | Phone :-  |

* ***PERSON(S) NOT AUTHORISED TO PICK UP YOUR CHILD***

|  |  |  |
| --- | --- | --- |
| NAME : - | RELATIONSHIP :- | PHONE:-  |
| NAME : - | RELATIONSHIP :- | PHONE :-  |
| NAME :- | RELATIONSHIP :-  | PHONE :- |
| NAME :-  | RELATIONSHIP :-  | PHONE :-  |

* ***CUSTODY AGREEMENT***

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| YES:-  | NO: - |
| IS YES, PLEASE PROVIDE A COPY OF THE CUSTODY ORDER TO THE FACILITY MANAGER/LICENSEE. |

* ***ALTERNATE PERSON(S) TO CALL AND PICK UP CHILD IN CASE OF EMERGENCY***

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| --- | --- | --- |
| NAME : - | RELATIONSHIP: - | PHONE : - |
| NAME : - | RELATIONSHIP : - | PHONE : - |
| NAME : -  | RELATIONSHIP :-  | PHONE : - |
| NAME : -  | RELATIONSHIP :-  | PHONE : - |

* ***HEALTH INFORMATION***

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| REGULAR MEDICATION(S) AND REASONS FOR (please list): -  |
| ALLERGIES AND TREATMENTS OF (please list): -  |

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| INJURY(S), ILLNESS(ES) OR OPERATIONS YOUR CHILD HAD AND INCLUDE DATES :-  |
| 1. Please describe any concerns/issues regarding your child’s health (seizures, asthma, vision, hearing, etc.)
 |
| 1. Please describe any concerns you may have regarding your child’s development (e.g. behaviour, vision, hearing, speech, language, mobility etc.)
 |
| 1. Describe any specific care instruction regarding a) and b):-
 |
| 1. Other health care professionals involved in your child’s life. e/g occupational therapist/physical therapist: -

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* ***GROUP EXPERIENCES***

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| WHAT IS /ARE YOUR CHILD’S FAVOURITE TOY(S) ACTIVITIES: -  |
| HAS YOUR CHILD HAD PREVIOUS PLAY GROUP EXPERIENCES? - YES -NO |
| IF YES, HOW DID HE/SHE ADAPT? |
| HOW DOES YOUR CHILD BEHAVE TOWARD OTHER CHILDREN (E.G, SEEK OTHERS OUT, FEELS SHY)?-  |

* ***EMOTIONAL***

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| 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 THE PROGRAM EASIER? |

* ***FAMILY AND GENERAL HOUSEHOLD INFORMATION***

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| PLEASE 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 IN THE HOME:  |
| OTHER LANGUAGES: -  |

* ***EATING AND NUTRITION***

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| LIST YOUR CHILD’S FAVOURITE FOOD: -  |
| LIST ANY DISLIKED FOOD: -  |
| PLEASE DESCRIBE ANY PARTICULAR EATING PATTERNS: -  |
| ARE THERE ANY RELIGIOUS OR ETHNIC OBSERVATIONS RELATED TO FOODS: -  |

* ***SLEEPING***

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| --- | --- |
| NAP TIME: -  | HOW LONG TO SETTLE: -  |
| IS YOUR CHILD DEEP SLEEPER, OR DOES (S)HE AWAKEN EASILY? |
| DOES YOUR CHILD TAKE A FAVOURITE COMFORTER (E.G BLANKET OR TOY? |
| WHAT IS YOUR CHILD’S MOOD UPON WAKENING? |

* ***TOILETING***

|  |  |  |  |
| --- | --- | --- | --- |
| IS YOUR CHILD TOILET TRAINED  | YES | NO | PARTIALLY |
| PLEASE INDICATE YOUR CHILD’S FREQUESNCY OR PATTERNS FOR BOWEL MOVEMENTS: - |
| DESCRIBE ASSISTANCE NEEDED FOR TOILETING: - |
| WHAT “SPECIAL” WORD DOES YOR CHILD USE FOR:- URINATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BOWEL MOVEMENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

* ***OTHER COMMENTS***

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* ***CHILD IMMUNIZATION RECORD***