Beyond Element Childcare
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beyondelementchildcare@gmail.com

Registration Form for Child Care

FACILITY NAME:	
FULL NAME OF CHILD:	**USUAL NAME OF CHILD [IF DIFFERENT]:**

Personal Information

CHILD'S DATE OF BIRTH:	GENDER:	STARTING DATE:
ADDRESS:		POSTAL CODE: PHONE: ( )
PARENT OR GUARDIAN:		PARENT OR GUARDIAN:
ADDRESS [IF DIFFERENT FROM ABOVE]:		ADDRESS [IF DIFFERENT FROM ABOVE]:
PHONE:		PHONE:
WORK ADDRESS/ALTERNATE LOCATION:		WORK ADDRESS/ALTERNATE LOCATION:
PHONE [INCLUDE LOCAL]:		PHONE [INCLUDE LOCAL]:
CELLULAR/PAGER:		CELLULAR/PAGER:
HOURS AT THIS LOCATION:		HOURS AT THIS LOCATION:

Emergency Health Information

CARE CARD NUMBER:			
FAMILY DOCTOR/CLINIC NAME:		FAMILY DENTIST/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:	

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:

Persons(s) not Authorized to Pick Up Your Child

NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

Custody Agreement: ☐ YES ☐ NO

IF YES, SUPPLY A COPY OF THE CUSTODY ORDER TO THE FACILITY MANAGER/LICENSEE

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 UP TO DATE ON IMMUNZATIONS? ☐ **YES** ☐ **NO** ☐ **NOT IMMUNIZED**

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.		

COMMENTS:

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):

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

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

c) Describe any specific care instruction regarding a) and/or b):

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

Group Experiences

WHAT IS/ARE YOUR CHILD'S FAVOURITE 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?

Family and General Household Information

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:
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:	

Additional Child History
(Optional)

Eating and Nutrition

LIST YOUR CHILD'S FAVOURITE FOOD:

LIST ANY DISLIKED FOOD:

PLEASE DESCRIBE ANY PARTICULAR EATING PATTERNS:

ARE THERE ANY RELIGIOUS OR ETHNIC OBSERVANCES RELATED TO FOODS:

Sleeping

NAP TIME:	HOW LONG TO SETTLE	TIME OF WAKING:
BEDTIME:	HOW LONG TO SETTLE	TIME OF WAKING:

IS YOUR CHILD A DEEP SLEEPER, OR DOES (S)HE AWAKEN EASILY?

DOES YOUR CHILD TAKE A FAVOURITE COMFORTER [E.G., BLANKET OR TOY] TO BED? ☐ YES ☐ NO

IF YES, PLEASE DESCRIBE AND TELL US IF IT IS "NAMED":

WHAT IS YOUR CHILD'S MOOD UPON WAKENING?

Toileting

IS YOUR CHILD TOILET-TRAINED? ☐ YES ☐ NO ☐ PARTIALLY

PLEASE INDICATE YOUR CHILD'S FREQUENCY OR PATTERNS FOR BOWEL MOVEMENTS:

DESCRIBE ASSISTANCE NEEDED FOR TOILETING:

WHAT "SPECIAL" WORD DOES YOUR CHILD USE FOR:

URINATION: _____ BOWEL MOVEMENTS _____

Administration of Medication Consent Form

CHILD'S NAME:		
PHYSICIAN'S NAME:		PHONE:
PHARMACY NAME:		PHONE:
MEDICATION:		PRESCRIPTION #:
DOSAGE OF MEDICATION:	HAS THIS MEDICATION BEEN ADMINISTERED TO THIS CHILD PREVIOUSLY? ☐ YES ☐ NO IF NO, HAS CHILD RECEIVED MEDICATION FOR 24 HRS PRIOR TO RETURNING TO THE CHILD CARE PROGRAM? ☐ YES ☐ NO	
TIMES TO BE GIVEN BY PARENT:		
TIMES TO BE GIVEN BY CARE PROVIDER:		
ANY POSSIBLE SIDE EFFECTS THAT YOU HAVE BEEN MADE AWARE OF BY THE PHYSICIAN OR PHARMACY?		

I hereby give permission and authorize _____ to administer the medication in the dosage as stated above. This dosage is consistent with the recommendations of the Physician and/or drug manufacturer. I accept the responsibility of supplying the current correct medication in its original container, and I agree to submit a new consent form if there is any change in the medication to be administered.

_____	_____	_____
Signature of Parent/Guardian	Date	Phone

Caregiver's Administration Record:

DATE:	TIME GIVEN:	AMOUNT GIVEN:	ADMINISTERED BY:

Immunization Record Declaration

Community Care Facilities (CCF) licensed to provide care to children or youth are required to have a copy of the Immunization Record on file for each person in care in the event that an outbreak of a communicable disease should occur. This information will assist in the immediate exclusion of those who are unimmunized.

In recent years, CCF's appear to be having difficulty in acquiring a copy of the Immunization Record from families and facilities are being coded for being in non-compliance with the legislation.

Although Licensing expects a copy of the immunization record to be on file for each person in care, this form has been provided to:

- assist in identifying those children who are not fully immunized and
- assist CCF's in meeting Section 21(1) (a) of the *Child Care Licensing Regulation.*

To be completed by Parent/Guardian:

_____ _____

Child's/Youth's Name | Date of Birth

Complete Immunization:

- ❑ Written proof of vaccinations attached
- ❑ Written proof of vaccinations unavailable

Received immunization in:

_____ _____ _____ _____

Year of last Vaccine | City | Province | (If not in Canada, include country)

Incomplete Immunization:

- ❑ My child has had some vaccinations
- ❑ My child has no vaccinations
- ❑ I do not know

Parent's/Guardian's Printed Name	Date
Parent's/Guardian's Signature	