

Bright Minds Child Care Centre

PRESCHOOL CLASSES REGISTRATION FORM

Class (Circle One): 3 year Old Morning Afternoon
 4 Year Old Morning Afternoon

| | |
|-----------------------------|-------------------------------------|
| NAME OF CHILD: | |
| BIRTHDATE: (Day/Month/Year) | USUAL NAME OF CHILD (IF DIFFERENT): |

| PERSONAL INFORMATION | |
|----------------------------------|---------------------------------|
| GENDER | START DATE: |
| ADDRESS: | PHONE NUMBER: |
| MOTHER OR GUARDIAN: | FATHER OR GUARDIAN: |
| ADDRESS: | ADDRESS (IF DIFFERENT) |
| HOME PHONE: | HOME PHONE (IF DIFFERENT) |
| WORK ADDRESS/ALTERNATE LOCATION | WORK ADDRESS/ALTERNATE LOCATION |
| PHONE (INCLUDE LOCAL) | PHONE (INCLUDE LOCAL) |
| CELLULAR/PAGER: | CELLULAR/PAGER: |
| PERSON(S) WHOM CHILD LIVES WITH: | EMAIL ADDRESS: |

| 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 center to call a medical practitioner or ambulance in the case of accident or illness of my child(ren), <u>if the parent cannot immediately be reached.</u> | |
| 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: |

| PERSON(S) NOT AUTHORIZED TO PICK UP CHILD | | |
|---|---------------|--------|
| NAME: | RELATIONSHIP: | PHONE: |
| NAME: | RELATIONSHIP: | PHONE: |

| | | |
|---|------------|-----------|
| CUSTODY AGREEMENT: | Yes | No |
| (Please circle one) | | |
| IF YES, SUPPLY A COPY OF THE CUSTODY ORDER TO THE FACILITY/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: |

* Please let these people know they are your child's emergency contact.

| CHILD'S IMMUNIZATION STATUS (Please record dates (Year/Month/Day) or attach copy of immunization) | | | | | |
|--|-----------|---------|-------|--------------------------------|-----|
| IS YOUR CHILD IMMUNIZED? (Please Circle One) 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. | | |
| 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 OPERAITONS 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 HEATH CARE PROFESSIONALS INVOLVED IN YOUR CHILD'S LIFE, E.G., OCCUPATIONAL, THERAPIST/PHYSICAL THERAPITS:

GROUP EXPERIENCES

WHAT IS/ARE YOUR CHILD'S FAVOURITE ACTIVITIES:

HAS YOUR CHILD HAS PREVIOUS 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: |

| |
|----------------------------|
| ANY OTHER COMMENTS: |
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| 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. All information is kept strictly confidential.

| <i>FACILITY USE ONLY</i> | | |
|--|------------------------|-------|
| <i>Staff person reviewing family's document:</i> | | |
| SIGNATURE: | PRINT NAME: | DATE: |
| CHILD'S WITHDRAWAL DATE: | REASON FOR WITHDRAWAL: | |

BRIGHT MINDS
PRESCHOOL PROGRAM

PERMISSION FORM AND PARENT'S AGREEMENT

I, _____ shall at this time enter into an agreement with Bright Minds Child Care Centre, for the care of my child (ren),

I agree to submit post-dated cheques for each school year (or month child starts) to June and to give **one full month's notice** of withdrawal of my child from Bright Minds Preschool Program. Summer School Program Cheques will be due in March of that year. After the 30-day notice has been received, we will return all unused cheques. There will be a \$20.00 charge on all returned (N.S.F.) cheques. Please Initial: ►()

A \$25.00 registration fee is required to ensure your child a place and is not refundable. Please Initial: ►()

There will be no refund on monthly fees or any portion thereof, regardless of sickness, school holidays or family vacations. Please Initial: ►()

Cancellation Notice

One full calendar's month must be given for withdrawal of your child. **There will be no withdrawals after March 1st.** Please Initial: ►()

I have read and understood the policies and procedures as set forth in the Bright Minds Parent Handbook. Please Initial: ►()

Signed: _____

Date: _____