



# YUS Montessori School

## REGISTRATION FORM FOR CHILD CARE

Full Day    AM    PM

FACILITY NAME: <b>YUS Montessori School</b>	
FULL NAME OF CHILD:	USUAL NAME OF CHILD (IF DIFFERENT):

PERSONAL INFORMATION		
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	
<b>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.</b>	
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: