fraserhealth

COMMUNITY CARE FACILITIES LICENSING

# 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 ☐ Male ☐ Female | STARTING DATE | |
|---|---|---|---|
| ADDRESS | | | FACILITY USE ONLY<br>WITHDRAWAL DATE |
| POSTAL CODE | TELEPHONE ( ) | | |

| PARENT OR GUARDIAN | PARENT OR GUARDIAN |
|---|---|
| ADDRESS *(if different from above)* | ADDRESS *(if different from above)* |
| TELEPHONE ( ) | TELEPHONE ( ) |
| WORK ADDRESS / ALTERNATE LOCATION | WORK ADDRESS / ALTERNATE LOCATION |
| TELEPHONE *(Include Local / Extension)* ( ) | TELEPHONE *(Include Local / Extension)* ( ) |
| CELL PHONE / PAGER ( ) | CELL PHONE / PAGER ( ) |
| HOURS AT THIS LOCATION | HOURS AT THIS LOCATION |

## EMERGENCY HEALTH INFORMATION

| CARE CARD NUMBER | |
|---|---|
| FAMILY DOCTOR / CLINIC NAME | DOCTOR / CLINIC TELEPHONE ( ) |

## CONSENT FOR EMERGENCY CARE

I authorize the staff at the child care centre to call a medical practitioner or ambulance / transport child to emergency medical care, in the case of accident or illness of my child(ren), if the parent cannot immediately be reached. Yes ☐ No ☐

## ALTERNATE PERSONS(S) AUTHORIZED TO PICK UP CHILD *(other than parent/guardian listed above, include emergency pickup)*

*Check all that apply*

| Name | Relationship | Telephone | Authorized to Pickup | Authorized to Call in an Emergency |
|---|---|---|---|---|
| | | | ☐ | ☐ |
| | | | ☐ | ☐ |

## PERSONS(S) WHO ARE NOT PERMITTED ACCESS TO MY CHILD

| Name | Relationship | Telephone |
|---|---|---|
| | | |
| | | |

## Community Care Facilities Licensing
# Registration Form for Child Care

fraserhealth

| | | |
|---|---|---|
| | | |
| | | |

**CUSTODY OR OTHER LEGAL ORDERS**

| | |
|---|---|
| Yes ☐ No ☐ | If yes, supply a copy of the order to the facility Manager / Licensee |

**CHILD'S IMMUNIZATION STATUS**

| | |
|---|---|
| Is your child up to date on immunizations? | Yes ☐ No ☐ Not Immunized ☐ |

COMMENTS

**HEALTH INFORMATION** *(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 concern(s) / 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, hearing, speech, language, mobility, etc.)

3. Describe any specific care instruction regarding 1) and/or 2) above.

OTHER HEALTH CARE PROFESSIONALS INVOLVED IN YOUR CHILD'S LIFE *(e.g. occupational therapist / physical therapist)*

**ANY OTHER INFORMATION I SHOULD KNOW**

**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** *(Facility has provided a copy of the following)*

1. Prepayment policy Yes ☐ No ☐
2. Behavioural Guidance Yes ☐ No ☐

## Community Care Facilities Licensing
# Registration Form for Child Care

fraserhealth

## ADDITIONAL INFORMATION ABOUT YOUR CHILD (OPTIONAL)

### 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 DESCIBE THE GUIDANCE AND DISCIPLINE METHODS USED AT HOME.

| | |
|---|---|
| PRIMARY LANGUAGE SPOKEN IN THE HOME | OTHER LANGUAGES |
| NAME OF ENGLISH SPEAKING PERSON (IFF NEEDED) | TELEPHONE |

### EATING AND NUTRITION

LIST YOUR CHILD'S FAVOURITE FOOD

LIST ANY DISLIKED FOOD.

PLEASE DESCIBE 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 |

DOES YOUR CHILD TAKE A FAVOURITE COMFORTER (E.G. BLANKET OR TOY) TO BED?
Yes ☐ No ☐ IF YES, 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: _____ |

## Community Care Facilities Licensing

# Child Immunization Status Declaration

fraserhealth

Community Care Facilities (that are licensed to provide care to children are required to have a copy of the Immunization Status on file for each child in care, in the event that an outbreak of a communicable disease should occur. This information will assist in identifying those that may require exclusion because they are not immunized.

This form has been provided to:

- Assist in identifying those children who are not fully immunized and
- Assist licensees in meeting Section 57(2)(a) of the *Child Care Licensing Regulation*.

**To be completed by Parent/Guardian:**

_____ _____

Child's Name | Date of Birth

**Complete Immunization:**

☐ Record on vaccinations attached

☐ Record on 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 Signatures

## Community Care Facilities Licensing

# Medical Administration Consent

fraserhealth

| CHILD'S NAME | |
|---|---|
| MEDICATION | PRESCRIPTION # *(if applicable)* |
| DOSAGE OF MEDICATION | HAS THE CHILD TAKEN MEDICATION BEFORE? Yes ☐ No ☐ |
| TIMES OR SYMPTOMS FOR WHEN MEDICATION IS TO BE GIVEN BY CARE PROVIDER | |
| ANY POSSIBLE SIDE EFFECTS THAT YOU HAVE BEEN MADE AWARE OF BY THE PHYSICIAN OR PHARMACY? | |

I authorize the administration of the above medication, in the dosage and frequency stated above to my child. This dosage is consistent with the recommendations of the Physician and/or drug manufacturer. I accept the responsibility of supplying the **correct medication in its original container**. I will submit a new consent form if there are any changes to this medication, the dosage or the frequency of administration.

| Signature of Parent/Guardian | Date | Telephone |
|---|---|---|
| | | |

**ADMINSTRATION RECORD** *(completed by the caregiver administering the medication)*

| **Date** *(dd/mmm/yyyy)* | **Time Given** *(hr / min)* | **Dosage Administered** | **Administered by** *(signature)* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

fraserhealth

## EMERGENCY CONSENT CARD

_____
Name of Facility

Child's Name: _____ (Surname / First Name(s))

Birthdate: _____ (Year / Month / Day)

Address: _____

_____

Gender of Child: ☐ Male ☐ Female

1. Parent's Name:_

Child lives with: _____

Work Phone: _____

Home Phone: _____

2. Parent's Name: _____

Work Phone:_____

Home Phone: _____

Emergency Contact:_____

Phone: _____

Child's Doctor: _____

Phone: _____

1. Allergies _____

2. Medications _____

Care Card #: _____

252700 | AUG 2019

## CONSENT FORM

It is the policy of this centre to notify a parent when a child is ill or needs medical attention. In the event we cannot contact you and we need to get immediate help for your child, we require a signed consent to do so.

1. I give consent for my child to be taken to the nearest emergency medical centre when I cannot be contacted.
2. I give consent for my child to receive medical treatment.

_____
Signature of Parent/Guardian

Picture of Child

_____
Witness

_____
Date

**Personal information contained on this form is collected under the Community Care and Assisted Living Act and will be used only for the purpose indicated.**


fraserhealth

## EMERGENCY CONSENT CARD

_____
Name of Facility

Child's Name: _____ (Surname / First Name(s))

Birthdate: _____ (Year / Month / Day)

Address: _____

_____

Gender of Child: ☐ Male ☐ Female

1. Parent's Name:_

Child lives with: _____

Work Phone: _____

Home Phone: _____

2. Parent's Name: _____

Work Phone: _____

Home Phone: _____

Emergency Contact:_____

Phone: _____

Child's Doctor: _____

Phone: _____

1. Allergies _____

2. Medications _____

Care Card #: _____

252700 | AUG 2019

## CONSENT FORM

It is the policy of this centre to notify a parent when a child is ill or needs medical attention. In the event we cannot contact you and we need to get immediate help for your child, we require a signed consent to do so.

3. I give consent for my child to be taken to the nearest emergency medical centre when I cannot be contacted.
4. I give consent for my child to receive medical treatment.

_____
Signature of Parent/Guardian

Picture of Child

_____
Witness

_____
Date

**Personal information contained on this form is collected under the Community Care and Assisted Living Act and will be used only for the purpose indicated.**

# TRANSPORTATION AUTHORIZED PICKUP/DROP-OFF PERSON FORM

Child's Name: _____

Date of Birth: _____ Gender: _____

Parent/Guardian Name: _____

Contact Number: _____

Daycare Start Date: _____

**AUTHORIZED PICKUP/DROP-OFF PERSONS:**

Please provide the names and contact information of individuals authorized to pick up or drop off the child at the daycare. This information will be used to ensure the safety and security of the child during transportation.

| | |
|---|---|
| Full Name: _____<br>Relationship to Child: _____<br>Contact Number: _____ | Full Name: _____<br>Relationship to Child: _____<br>Contact Number: _____ |
| Full Name: _____<br>Relationship to Child: _____<br>Contact Number: _____ | Full Name: _____<br>Relationship to Child: _____<br>Contact Number: _____ |
| Full Name: _____<br>Relationship to Child: _____<br>Contact Number: _____ | Full Name: _____<br>Relationship to Child: _____<br>Contact Number: _____ |

Please indicate below if there are any specific instructions or restrictions regarding the authorized pickup/drop-off persons.

_____

_____

_____

Parent/Guardian Signature: _____ Date: _____