

Name of Facility: _____

CHILD'S START DATE: ____/____/____
YY MM DD

SEX: M ____ F ____

DATE OF BIRTH: ____/____/____
YY MM DD

NAME OF CHILD: _____
(Surname) (Given Names) (Also Known As)

Name the child responds to: _____

Address: _____

Postal code: _____ Phone: _____

Person(s) with whom the child lives (adults and children): _____

Child's first language: _____ Other languages: _____

Parent(s) / guardian(s):

Name: _____ Home phone: _____ Cell phone: _____

Work phone: _____ Days/hours of work: _____ E-mail: _____

Name: _____ Home phone: _____ Cell phone: _____

Work phone: _____ Days/hours of work: _____ E-mail: _____

Person(s) authorized to pick up the child and be contacted in case of emergency. These people should be available during hours of care. (include mother / father / guardian):

Name: _____ Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Name: _____ Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Name: _____ Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Name: _____ Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

If appropriate, list an English speaking contact:

Name: _____ Phone: _____

Has the child previously attended davcare/preschool?

YES NO Comments: _____

Comments/instructions to help us care for your child. (Please feel free to add additional pages.):

Toileting/Diapering (special words): _____

Rest time (special comfort – toy/blanket): _____

Eating/Mealtime (include food likes/dislikes): _____

Fears: _____

Please tell us anything else you think will help us provide an enriching experience for your child: _____

HEALTH INFORMATION

Health professionals involved with your child (other than doctor and dentist):

NAME	PROFESSION/AGENCY	Phone: _____
_____	_____	_____
_____	_____	Phone: _____
_____	_____	Phone: _____

Does your child have:

A medical condition/concern? YES NO
If yes, please provide further information: _____

Allergies? YES NO
If yes, please provide further information: _____

Asthma? YES NO
If yes, please provide further information: _____

Has your child had a seizure in the past year? YES NO
If yes, please provide further information: _____

Does your child require a special diet related to a medical condition? YES NO
If yes, please provide further information: _____

Food sensitivities? YES NO
If yes, please provide further information: _____

List all prescription and "over the counter" medications your child receives:

Medication	Times Given	Reason for Medication
_____	_____	_____
_____	_____	_____

You may be asked to complete additional forms if you answered yes to any of the above.

The above health information may be made available to the staff of Vancouver Coastal Health.

Custody Agreement YES N/A **Provided to Facility** YES NO N/A

Photocopy of Immunization Records Provided to the Facility YES NO

Parent/Guardian: _____ / _____ / _____
Name Signature YY MM DD

Staff/Caregiver: _____ / _____ / _____
Name Signature YY MM DD

<u>Office Use Only</u>
Date child leaves the facility: _____ / _____ / _____ YY MM DD