REGISTRATION FORM FOR SAHHALTKUM DAYCARE

CHILD'S FULL NAME:_____

NICKNAME OR PREFERRED NAME:_____

DATE OF BIRTH:_____

PARENT (S) OR GUARDIAN (S):_____

MAILING & HOME ADDRESS:_____

MOTHER:_____HOME PHONE:_____CELL #:_____

FATHER:_____ HOME PHONE:_____CELL #:_____

MOTHER'S PLACE OF EMPLOYMENT OR SCHOOL:_____
WORK/SCHOOL ADDRESS:_____
WORK/SCHOOL PHONE:_____
REGULAR WORKING/SCHOOL HOURS:_____TO_____

FATHER'S PLACE OF EMPLOYMENT OR SCHOOL:_____
WORK/SCHOOL ADDRESS:_____
WORK/SCHOOL PHONE:_____
REGULAR WORKING/SCHOOL HOURS:_____TO_____

IF APPLICABLE:

NAME OF BAND REGISTERED WITH:_____BAND #_____

ALTERNATE CONTACT:_____PHONE:_____

RELATIONSHIP:_____

BROTHERS OR SISTERS:

NAMES: AGES:

_____ _____

_____ _____

_____ _____

_____ _____

OTHER MEMBERS IN YOUR HOUSEHOLD (INCLUDE RELATIONSHIPS):_____

_____

HALF DAYS: AM/PM_____FULL DAYS:_____

AFTER SCHOOL:_____ DROP IN:_____

CIRCLE: MON. TUES. WED. THURS. FRI.

ARRIVAL DEPARTURE TIME:_____

DATE OF ENTRY:_____

GETTING TO KNOW YOUR CHILD

FEEDING TIMES:

IS YOUR CHILD BOTTLE FED OR ON SOLID FOODS?

BOTTLE:_____ SOLID FOODS:_____

TYPE OF MILK/FORMULA:_____BABY FOODS:_____

PLEASE GIVE DETAILS AND ANY SPECIAL FEEDING INSTRUCTIONS:

IF ON THE BOTTLE, DO YOU ALWAYS HEAT YOU BOTTLES? PLEASE EXPLAIN.

IF YOUR CHILD IS ON SOLID FOODS,WHAT TYPES OF FOOD DOYOU GENERALLY FEED HIM/HER?_____

WHAT ARE YOUR CHILDS FOOD LIKES AND DISLIKES? _____

DOES YOUR CHILD HAVE ANY SPECIAL EATING HABITS THAT WE SHOULD BE AWARE OF? (IE. GAGS, THROWS FOOD,ETC.)_____

PLEASE GIVE DETAILS OF ANY SPECIAL INSTRUCTIONS AROUND EATING:_____

DOES YOUR CHILD HAVE ANY KNOWN **FOOD ALLERGIES**? IF SO, TO WHAT TYPE OF FOOD AND WHAT WOULD THEIR ALLERGIC REACTION BE? _____

_____

NAP TIMES:

DOES YOUR CHILD USUALLY NAP? YES_____NO_____FOR HOW LONG:_____

DOES YOUR CHILD USUALLY SLEEP WELL? (light sleeper, etc.)_____

DOES YOUR CHILD HAVE A SPECIAL TOY, DOLL OR BLANKET THAT THEY GENERALLY SLEEP WITH?_____

DOES YOUR CHILD HAVE NIGHTMARES, BEDWETTING, ETC?_____

DOES YOUR CHILD TAKE A BOTTLE OR SOOTHER DURING NAP? YES___NO_____

HOW DO YOU GENERALLY PUT YOUR CHILD DOWN FOR A NAP? (ie. storytelling, music, etc.)_____

_____

DIAPERING/TOILETING:

IS YOUR CHILD USING DIAPERS? CLOTH_____PAMPERS:_____

DOES YOUR CHILD REACT TO ANY OF THE FOLLOWING ITEMS:

BABY WIPES: YES:_____NO:_____

BABY POWDER/CRNSTARCH: YES:_____NO:_____

OINTMENTS (i.e. zincofax): YES:_____NO_____

IS YOUR CHILD POTTY TRAINED? YES:_____NO:_____

BEING TRAINED? YES:_____NO:_____

DOES YOUR CHILD USE A POTTY SEAT OR A REGULAR SEAT?_____

PLEASE DESCRIBE ACTIONS OR WORDS YOUR CHILD REFERS TO WHEN HE/SHE NEEDS TO GO TO THE WASHROOM:_____

_____

EMOTIONAL:

WHAT TYPE OF REACTION MAY WE EXPECT OF YOUR CHILD WHEN THEY ARE BEING LEFT BY EITHER THEIR PARENT OR GUARDIAN? (seperation):_____

DOES YOUR CHILD HAVE ANY KNOWN FEARS? (dogs, new places, etc.)_____

WHAT DO YOU USUALLY DO TO COMFORT YOUR CHILD?_____

CAN YOU BRIEFLY DESCRIBE YOUR CHILD'S BEHAVIOUR AND PERSONALITY: (shy, outgoing, happy, etc.)_____

_____

SOCIAL:

HAS YOUR CHILD BEEN IN A DAYCARE PROGRAM OR PRIVATE HOMECARE SITUATION IN THE PAST? YES_____NO_____

IF YES, WHERE AND FOR WHAT LENGTH OF TIME:_____

IS YOUR CHILD USED TO PLAYING WITH OTHER CHILDREN OR DOES HE/SHE MIX WELL WITH OTHER CHILDREN?_____

LIST ANY SPECIAL FRIENDS OR RELATIVES YOUR CHILD MAY ASSOCIATE WITH REGULARLY (NAMES)_____

_____

RELATIONSHIP/COMMENTS:_____

IF APPLICABLE:

WHAT TYPES OF CULTURAL ACTIVITIES HAS YOUR CHILD EXPERIENCED? (Stick games, dancing, etc.)_____

_____

DO YOU THE PARENTS/GUARDIANS HAVE ANY CULTURAL KNOWLEDGE YOU WOULD LIKE TO SHARE WITH THE DAYCARE? YES_____NO_____

IF YES, PLEASE EXPLAIN_____

OTHER:

WHAT ARE YOUR CHILD'S FAVORITE ACTIVITIES AND INTERESTS (Walks, outside, etc.)_____

_____

ARE THERE ANY AREAS IN YOUR CHILD'S DEVELOPMENT THAT YOU WOULD LIKE US AS CAREGIVERS TO FOCUS ON?_____

ARE THERE ANY SPECIAL COMMENTS OR INSTRUCTIONS FOR THE CAREGIVERS?

_____

HEALTH HISTORY:

HOW IS YOUR CHILD'S GENERAL HEALTH?_____

HAS YOUR CHILD HAD ANY CONTAGIOUS DISEASES? YES_____NO_____

IF SO, CHECK OFF THE FOLLOWING:

CHICKEN POX	_____	AGE: _____
MUMPS	_____	AGE: _____
MEASLES	_____	AGE: _____
DIPTHERIA	_____	AGE: _____
TETNUS	_____	AGE: _____
WHOOPING COUGH	_____	AGE: _____
TUBERCULOSIS	_____	AGE: _____
RUBELLA	_____	AGE: _____
MENINGITIS	_____	AGE: _____
OTHER:	_____	AGE: _____

IS YOUR CHILD UPDATED ON HIS/HER IMMUNIZATIONS? YES_____NO_____
(WE NEED A COPY OF UPDATED IMMUNIZATIONS BEFORE YOUR CHILD STARTS)

DATE OF LAST MEDICAL EXAMINATION:_____

ARE THERE ANY INDICATIONS OF VISION OR HEARING PROBLEMS?_____

HAS YOUR CHILD RECEIVED ANY SERVICES FOR SPEECH THERAPY?_____

ANY HANDICAPS (Eyes, ears, feet, etc.)_____

_____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING:

OPERATIONS:_____

ACCIDENTS:_____

INJURIES:_____

PLEASE SHARE WITH US ANY ASSESSMENTS OR REPORTS REGARDING YOUR CHILD THAT WOULD ASSIST US IN PROVIDING THE BEST AND SAFEST CARE FOR YOUR CHILD_____

PERSONAL EMERGENCY INFORMATION

CHILD'S NAME:_____

DATE OF BIRTH:_____

	NAME	PHONE #
PEDIATRICIAN:	_____	_____
FAMILY PHYSICIAN:	_____	_____
DENTIST:	_____	_____

MEDICAL INSURANCE NUMBER:_____

ALLERGIES: (WHAT IS THEIR REACTION – GIVE DETAILS)

_____

_____

CHRONIC CONDITIONS:

_____

_____

SPECIAL INFORMATION AND PRECAUTIONS:

_____

_____

MOTHER'S NAME:_____HOME #_____WORK #_____

FATHER'S NAME:_____HOME #_____WORK #_____

EMERGENCY CONTACT PERSON(S): Please ensure that when listing this person, you feel comfortable allowing us to release your child to them in an EMERGENCY SITUATION ONLY.

NAME:_____HOME #_____WORK #_____

RELATIONSHIP TO CHILD:_____

IN THE EVENT OF ILLNESS, DOES THIS PERSON HAVE YOUR PERMISSION TO TAKE THE CHILD HOME FROM THE CENTRE: YES:_____NO:_____

DATE FILLED OUT:_____

EMERGENCY FORM

IT IS OUR POLICY TO NOTIFY THE PARENT(S) OR GUARDIAN(S) WHEN A CHILD IS ILL OR NEEDS MEDICAL ATTENTION. OCCASIONALLY, WE CANNOT REACH THE PARENT, GUARDIAN, OR EMERGENCY CONTACT PERSON AND WE NEED TO GET IMMEDIATE HELP FOR THE CHILD. PLEASE SIGN THE CONSENT BELOW, SO THAT WE CAN TAKE APPROPRIATE ACTION ON BEHALF OF YOUR CHILD. WE WILL TAKE THIS SIGNED CONSENT WITH US TO THE EMERGENCY CENTRE.

I AUTHORIZE THE STAFF OR PERSON(S) IN CHARGE OF THE SAHHALTKUM DAYCARE CENTRE TO:

- CALL A PHYSICIAN
- TAKE MY CHILD TO THE NEAREST EMERGENCY CENTRE
- SUMMON AN AMBULANCE FOR EMRGENCY MEDICAL AID

SHOULD THE PERSON(S) IN ATTENDANCE FEEL SUCH SERVICES ARE REQUIRED AND I CANNOT BE CONATACTED BY PHONE. I AGREE THAT ANY COST INCURRED FOR SUCH SERVICES SHALL BE THE SOLE RESPONSIBILITY OF MYSELF.

_____ _____

DATE SIGNITURE OF PARENT/GUARDIAN

ALTERNATE ARRANGEMENTS

CHILD(REN NAME(S):_____

IF MORE THAN ONE PERSON WILL BE DROPPING OFF OR PICKING UP YOUR CHILD(REN) FROM THE CENTRE, PLEASE LIST ALL PERSON(S):

NAME:_____PHONE:_____

NAME:_____PHONE:_____

NAME:_____PHONE:_____

NAME:_____PHONE:_____

*PLEASE NOTIFY THE DAYCARE IN WRITING ON DAYS IF YOUR CHILD WILL BE DROPPED OFF OR PICKED UP BY SOMEONE OTHER THAN THESE PERSONS. IF IT IS NOT POSSIBLE TO GET THIS TO US IN WRITING, YOU WILL NEED TO PHONE THE DAYCARE WITH A PHYSICAL DESCRIPTION OF THE PERSON AND THEY WILL NEED TO PROVIDE US WITH PICTURE IDENTIFICATION.