New Kids on the Block Daycare

Registration Form

FACILITY: Earl Grey (3-5yrs) ☐ Obed (3-5yrs) ☐ Obed Infants ☐ PHOTO ATTACHED: ☐

DATE OF ENROLLMENT MM / DD / YYYY TYPE OF ENROLLMENT: Full time ☐ Part time ☐ # of days _____

CHILD INFORMATION:

CHILD'S NAME SURNAME GIVEN MIDDLE NAME

NAME CHILD RESPONDS TO: GENDER: Male ☐ Female ☐

ADDRESS POSTAL CODE

DATE OF BIRTH MM / DD / YYYY FIRST DAY OF ATTENDANCE MM / DD / YYYY END DATE MM / DD / YYYY

PARENT / GUARDIAN INFORMATION:

PRIMARY CONTACT SURNAME GIVEN MIDDLE NAME

HOME ADDRESS POSTAL CODE

EMAIL ADDRESS PHONE: (H) (C)

PLACE OR WORK PHONE: (W)

WORK ADDRESS

SECONDARY CONTACT SURNAME GIVEN MIDDLE NAME

HOME ADDRESS POSTAL CODE

EMAIL ADDRESS PHONE: (H) (C)

PLACE OR WORK PHONE: (W)

WORK ADDRESS

ALTERNATE PERSON TO CALL/PICK-UP IN CASE OF ILLNESS OR EMERGENCY

NAME RELATIONSHIP PHONE:

NAME RELATIONSHIP PHONE:

NAME RELATIONSHIP PHONE:

PERSON(S) NOT AUTHORIZED ACCESS TO CHILD

NAME RELATIONSHIP PHONE:

NAME RELATIONSHIP PHONE:

ARE THERE CUSTODIAL ORDERS: Yes ☐ No ☐ IF YES, ATTACH DOCUMENTATION: ☐

MEDICAL INFORMATION:

FAMILY DOCTOR	PHONE:
MEDICAL B.C. CARECARD :	EFFECTIVE DATE MM / DD / YYYY

RECORD OF IMMUNIZATION STATUS (Attach document or record the date below):

Please check one of the following:

- ☐ Yes, my child has been immunized and I have provided the center with a copy of his/her immunization records
- ☐ Yes, my child has been immunized. At this time, I wish not to or I'm not able to provide immunization records
- ☐ No, my child is not immunized and I accept full responsibility for my child's health

First visit – two months of age MM / DD / YYYY

- ☐ Diphtheria, Tetanus, Pertussis, Hepatitis B, Polio, Haemophilus Influenzae type b
- ☐ Pneumococcal Conjugate
- ☐ Meningococcal C Conjugate
- ☐ Rotavirus

Second visit – four months of age MM / DD / YYYY

- ☐ Diphtheria, Tetanus, Pertussis, Hepatitis B, Polio, Haemophilus Influenzae type b
- ☐ Pneumococcal Conjugate
- ☐ Rotavirus

Third visit – 6 months of age MM / DD / YYYY

- ☐ Diphtheria, Tetanus, Pertussis, Hepatitis B, Polio, Haemophilus Influenzae type b
- ☐ Rotavirus
- ☐ Hepatitis A

Fourth visit – 12 months of age MM / DD / YYYY

- ☐ Measles, Mumps, Rubella
- ☐ Meningococcal C Conjugate
- ☐ Varicella (chicken pox)
- ☐ Pneumococcal Conjugate

Fifth visit – 18 months of age MM / DD / YYYY

- ☐ Diphtheria, Tetanus, Pertussis, Polio, Haemophilus Influenzae type b
- ☐ Hepatitis A

4-6 years of age MM / DD / YYYY

- ☐ Diphtheria, Tetanus, Pertussis, Polio,
- ☐ Measles, Mumps, Rubella

Other Immunizations:

MM / DD / YYYY _____
MM / DD / YYYY _____
MM / DD / YYYY _____
MM / DD / YYYY _____

EMERGENCY CONSENT:

It is our policy to notify the parent/guardian when a child is ill or needs medical attention. Occasionally, if we cannot reach the parent or an authorized person, we will take the child to the nearest emergency facility. Please sign the consent below so that we can take appropriate action on behalf of your child. We will take this signed consent document with us to the emergency center.

I authorize the staff at New Kids on the Block Daycare Inc. to call a physician, to take my child to the nearest emergency center, or to summon an ambulance for emergency medical aid should, in the opinion of the person(s) in attendance feel such services are required and I or an authorized person cannot be contacted by phone. If such emergency should arise, I shall be notified as soon as possible. I agree that any cost incurred for such services shall be the sole responsibility of myself.

_____ _____

Parent/Guardian Signature Date

_____

Parent/Guardian (print name)

GENERAL INFORMATION:

NAME OF OTHER CHILDREN LIVING AT HOME

NAME	DATE OF BIRTH MM / DD / YYYY
NAME	DATE OF BIRTH MM / DD / YYYY

OTHER INFORMATION:

HAS CHILD HAD PREVIOUS EXPERIENCE AWAY FROM HOME: Yes ☐ No ☐

IF YES, EXPLAIN:

WHERE: DATE OF ATTENDANCE MM / DD / YYYY TO. MM / DD / YYYY

WHY ARE YOU LEAVING THAT CARE:

DO YOU THINK YOUR CHILD FEELSCOMFORTABLE LEAVING PARENTS: Yes ☐ No ☐

EXPLAIN:

DOES YOUR CHILD HAVE ANY KNOWN HEALTH PROBLEMS, MEDICAL DISABILITIES OR SPECIAL NEEDS: Yes ☐ No ☐

IF YES, ATTACH DOCUMENTATION OR EXPLAIN:

DOES YOUR CHILD HAVE A SPECIAL NEEDS WORKER? Yes ☐ No ☐

LIST ANY COMMUNICABLE DISEASES CHILD HAS HAD:

HAS HE/SHE HAD ANY RECENT ILLNESSES: Yes ☐ No ☐

IF YES, EXPLAIN:

ANY ALLERGIES: Yes ☐ No ☐

IF YES, EXPLAIN AND ATTACH SPECIAL INSTRUCTIONS TO FOLLOW IN THE EVENT OF AN ALLERGIC REACTION:

WHAT IS YOUR CHILD'S EATING HABITS:

FAVORITE FOODS:

STRONG DISLIKES:

WOULD YOU LIKE YOUR CHILD TO NAP? Yes ☐ No ☐

IS YOUR CHILD TOILET TRAINED? Yes ☐ No ☐

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THE FOLLOWING:

I hereby acknowledge that I have read the Parent Handbook and agree to abide by all policies and regulations. All information provided above are true and accurate to the best of my knowledge.

Parent/Legal Guardian Name (print)	Parent/Legal Guardian Signature	Date
Manager Name (print)	Manager Signature	Date