

New Kids on the Block Daycare Registration Form

FACILITY:	Earl Grey (3-5yrs) <input type="checkbox"/>	Obed (3-5yrs) <input type="checkbox"/>	Obed I/T <input type="checkbox"/>	Bellamy (3-5yrs) <input type="checkbox"/>	Bellamy I/T <input type="checkbox"/>	PHOTO ATTACHED: <input type="checkbox"/>
DATE OF ENROLLMENT	MM / DD / YYYY		TYPE OF ENROLLMENT: Full time <input type="checkbox"/> Part time <input type="checkbox"/> Days: M T W Th F			

CHILD INFORMATION:

CHILD'S NAME	SURNAME	GIVEN	MIDDLE NAME
NAME CHILD RESPONDS TO:			GENDER: Male <input type="checkbox"/> Female <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/> IF YES, ATTACH DOCUMENTATION: <input type="checkbox"/>		

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 <input type="checkbox"/> No <input type="checkbox"/> 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 FEELS COMFORTABLE LEAVING PARENTS: Yes <input type="checkbox"/> No <input type="checkbox"/> EXPLAIN:
DOES YOUR CHILD HAVE ANY KNOWN HEALTH PROBLEMS, MEDICAL DISABILITIES OR SPECIAL NEEDS: Yes <input type="checkbox"/> No <input type="checkbox"/> IF YES, ATTACH DOCUMENTATION OR EXPLAIN:
DOES YOUR CHILD HAVE A SPECIAL NEEDS WORKER? Yes <input type="checkbox"/> No <input type="checkbox"/>
LIST ANY COMMUNICABLE DISEASES CHILD HAS HAD:
HAS HE/SHE HAD ANY RECENT ILLNESSES: Yes <input type="checkbox"/> No <input type="checkbox"/> IF YES, EXPLAIN:
ANY ALLERGIES: Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> IS YOUR CHILD TOILET TRAINED? Yes <input type="checkbox"/> No <input type="checkbox"/>

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

Parent Contract, Agreement & Consent

CHILD'S NAME:	SURNAME	GIVEN	MIDDLE NAME
CHILD'S NAME:	SURNAME	GIVEN	MIDDLE NAME
CHILD'S NAME:	SURNAME	GIVEN	MIDDLE NAME
PERSON(S) RESPONSIBLE FOR FEES:			
ADDRESS:		POSTAL CODE:	
EMAIL:	PHONE: (H)		(C)
DATE OF ENROLLMENT: MM/DD/YYYY	TYPE OF ENROLLMENT: Full time <input type="checkbox"/> ; Part time <input type="checkbox"/> Days: M T W Th F		
FEE PER MONTH:			

I/we have paid the \$75 registration fee and \$500 deposit for each child and acknowledge that it is non – refundable.

Once childcare services have started, I/we acknowledge that we require one Calendar Months' notice, regardless of whether my child attends the last month. The deposit will be applied to this last month and the difference will be paid as per the payment schedule. In instances where my child is not attending the last month, I understand that funding from ACCB (re. Subsidy and the Fee Reduction Initiative) may not be applicable as per ACCB regulations and I will responsible for the full parent portion of the fee.

I/we are aware that we are required to pay for every day our child(ren) is/are scheduled to attend New Kids on the Block Daycare subject only to the term on withdrawal and changes to attendance and that we must pay even if our child(ren) is/are absent due to illness, vacation, statutory holidays, closures or for any other reason.

I/we have been made aware of the conditions of enrollment and agree to follow those regulations.

I/we agree that my child may participate in outings, field trip and other activities without prior approval.

I/we agree to provide in writing one (1) full calendar months' notice to withdraw from the full or part-time program (e.g. notice given may 16 will be for July 1), change the start date, or decrease number of days of care, and agree that the notice is not valid until it is confirmed in writing by the site director.

I/we acknowledge that I/we have read the Parent Handbook and other relevant documents/amendments and I/we agree and consent to the rules, regulation and policies. My signature below indicates that the materials have been explained to be, that all my questions have been satisfactory answered and that I have received a copy of the Parent Handbook. I/We agree to comply with those policies and any changes to the policies in the future.

Parent/Legal Guardian Name (print)

Parent/Legal Guardian Signature

Date