



Registration Form

PERSONAL INFORMATION		START DATE:	
Full Name of Child:			
PROGRAM:		FULL TIME PART-TIME	
		DAYS:	
Usual Name of Child (if different):	Gender:	Child's Birth Date:	
Full Address:			
Mother/Legal Guardian:		Father/Legal Guardian:	
Address if different than above:		Address if different than above:	
Phone:		Phone:	
Email:		Email:	
Place of Work:		Place of Work:	
Work Address (or alternate location):		Work Address (or alternate location):	
Phone (include extensions):		Phone:	
Cellular:		Cellular:	
Hours at this location:		Hours at this location:	
Custody Agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide a copy of the custody order			

PERSON(S) AUTHORIZED TO PICK UP CHILD		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

ALTERNATE PERSON TO CONTACT IN EMERGENCY		
Please list persons other than parents. Parents will be contacted first in the case of an Emergency. Please list in order you wish to be contacted.		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

PERSON(S) NOT AUTHORIZED TO PICK UP CHILD		
If applicable, supply a copy of the Custody Order		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

EMERGENCY HEALTH INFORMATION	
Family Doctor/Clinic Name:	Phone:
Doctor/Clinic Address:	

CHILD'S IMMUNIZATION STATUS					
(Please record dates (year/month/day) or attach a copy of your child's immunization schedule)					
Is your child's immunizations up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Diphtheria	Pertussis	Tetanus	Polio	MMR (Measles/Mumps/Rubella)	HIB
1.	1.	1.	1.	1.	1.
2.	2.	2.	2.	2.	2.
3.	3.	3.	3.	Comments:	
4.	4.	4.	4.		
5.	5.	5.	5.		

CHILD'S HEALTH HISTORY				
Does your child have any known health problems? <i>Please check all that apply</i>				
<input type="checkbox"/> Asthma	<input type="checkbox"/> Earaches	<input type="checkbox"/> Mumps	<input type="checkbox"/> Whooping cough	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Eczema	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Frequent colds
<input type="checkbox"/> Croup	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Measles	<input type="checkbox"/> Influenza	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Chicken Pox	Other _____		
Please list any injuries or operations your child has had: Please include dates.				
Does your child have any known allergies? If yes, please list them:				
Does your child require an Epi-pen? If so, please fill out an Anaphylaxis Emergency Plan.				
Does your child have any regular medication? Please list reasons for medication.				
Does your child require occasional medication? i.e. puffers, fever suppressant. If so, please list reasons and symptoms that would indicate their need.				

Do you have any concerns about your child's development? i.e. behaviour, vision, speech, language, mobility

Do you have any concerns about your child's health? i.e. seizures, asthma

Any specific care instructions? Please attach separate sheet if necessary.

Is there any other medical information or special needs our staff should be aware of? Please attach separate sheet if necessary.

Other Health Care Professional Involved in your child's life? i.e. occupational therapist, physical therapist

EATING AND NUTRITION

List your child's favourite foods:

List any disliked foods:

Please describe any religious or ethnic observances related to foods:

SLEEPING HABITS

Naptime:	How long to settle:	Time of waking:
Bedtime:	How long to settle:	Time of waking:

Is your child a deep sleeper or does your child awaken easily?

TOILETING

Is your child toilet trained?

Describe assistance needed for toileting:

Does your child have any special words used to toileting?

PLAYGROUP EXPERIENCES

What are your child's favourite toys?

What types of play activities does your child enjoy?

How does your child behave towards other children? (seeks out others, shy, outgoing)

Please list any other daycare or preschool or group situations in which your child participated:
Were there any instances or situations our staff should be aware of?

EMOTIONAL
How does your child react with unfamiliar people or in unfamiliar situations?
Does your child have any particular fears?
What suggestions do you have to help staff make your child's transition into this program easier?

FAMILY AND GENERAL HOUSEHOLD INFORMATION	
Please list names of the significant people in your child's life (e.g. siblings, grandparents, pets)	
Please describe discipline methods at home:	
Primary language in the home:	English speaking contact (if applicable):
Other languages:	Phone:

PERMISSION FOR OUTINGS/FIELDTRIPS	
I hereby give permission for Small Steps Early Learning Centre to take my child, for local outings within the community. I understand these outings will follow the proper student to teacher ratio and travel will be by foot or local bus. (Large fieldtrips will require separate signatures on Fieldtrip form)	
Parent or Guardian Signature	Date

PERMISSION FOR PICTURE TAKING			
I hereby give my permission for Small Steps Early Learning Centre to take pictures of my child for: <i>check all that apply</i>			
<input type="checkbox"/> General record keeping	<input type="checkbox"/> Documentation in the centre	<input type="checkbox"/> Advertisement of the centre	<input type="checkbox"/> Website of the centre
Parent or Guardian Signature		Date	

EMERGENCY CARE



I authorize **Small Steps Early Learning Centre** to obtain the following services for my child if necessary: Public Health Nurse, Medical Practitioner, and or Ambulance. (All healthcare cost and ambulance fees are the responsibility of the parent/guardian.)

Parent or Guardian Signature	Date
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PARENT HANDBOOK	
I have read and understand all the policies and procedures in the Parent Handbook. I agree to follow by these guidelines and by not doing so it may lead to termination.	
Parent or Guardian Signature	Date

PARENT OR GUARDIAN SIGNATURE	
I completed this Registration Form to the best of my knowledge, without knowingly withholding any relevant or important information pertaining to my child.	
Parent or Guardian Signature	Date

CENTRE USE ONLY	
Small Steps Early Learning Centre STAFF PERSON REVIEWING FAMILY'S DOCUMENTS:	
Signature:	Print name:
Date:	Location:
Child's Withdrawal Date:	Reason For Withdrawal:
Deposit Received	Registration fee received