Registration Form

OFFICE USE ONLY

DEPOSIT RECEIVED ☐ $125 (☐ Cheque ☐ Cash ☐ Waived)

PROGRAM TYPE ☐ Part-Time. ☐ Full-Time

CHILD'S START DATE(YY/MM/DD): ______________________

SEX: MALE______FEMALE______ DATE OF BIRTH(YY/MM/DD): __________________

NAME OF CHILD: _________________ _________________ _________________
(SURNAME) (GIVEN NAME) ALSO KNOWN AS)

NAME OF THE CHILD RESPONDS TO:

____

ADDRESS:

____

PERSONS(S) WITH WHOM THE CHILD LIVES (ADULTS AND CHILDREN):

NAME: _______________________ RELATIONSHIPS_______________________

NAME: _______________________ RELATIONSHIPS_______________________

NAME: _______________________ RELATIONSHIPS_______________________

NAME: _______________________ RELATIONSHIPS_______________________

NAME: _______________________ RELATIONSHIPS_______________________

CHILD'S FIRST LANGUAGE: ___________________

ADDITIONAL LANGUAGES: ____________________

Any family, religious, and other special occasions that you would like to celebrate with us:

PARENT(S)/GUARDIAN(S):

1) NAME: ________________________HOME: _________________CELL: ______________

WORK: _________________ DAYS/HOURS OF WORK_________________

EMAIL____

2) NAME: ________________________HOME: _______________CELL: ________________

WORK: _________________ DAYS/HOURS OF WORK_________________

EMAIL____

3) NAME: ________________________HOME: _______________CELL: ________________

WORK: _________________ DAYS/HOURS OF WORK_________________

EMAIL____

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)

1) NAME: ________________________ RELATIONSHIPS________________________

HOME: _________________CELL: _________________ WORK: _________________

EMAIL____

2) NAME: ________________________ RELATIONSHIPS________________________

HOME: _________________CELL: _________________ WORK: _________________

EMAIL____

3) NAME: ________________________ RELATIONSHIPS________________________

HOME: _________________CELL: _________________ WORK: _________________

EMAIL____

IF APPROPRIATE, LIST AN ENGLISH-SPEAKING CONTACT

NAME: ________________________ RELATIONSHIPS________________________

HOME: _________________CELL: _________________ WORK: _________________

EMAIL____

HEALTH INFORMATION

PLEASE HELP US TO LEARN AND UNDERSTAND THE CHILD AS MUCH AS POSSIBLE BY KINDLY ANSWERING THE FLLOWING QUESTIONS BELOW

Health Professional involved with your child

NAME	PROFESSION/AGENCY	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:

____

www.seqouialearning.ca
12151 Shell Road, Richmond, BC, V7A 3W9
Phone: 604-275-6466
E-mail: info@sequoialearning.ca

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 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/Frequency	Reasons for Medication
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

FAMILY DOCTOR INFORMATION:

NAME: ___________________________ PHONE: ___________________________EXT:

NAME OF THE ORGANIZATION: ___________________________

*****<u>THE ABOVE HEAHLTH INFORMATION MAY BE MADE AVAILABLE TO THE STAFF OF VANCOUVER COASTAL HEALTH</u>

CUSTODY AGREEMENT: YES □ N/A □ PROVIDED TO FACILITY YES □ NO □ N/A □

PARENT/GUADRIAN: ____________________ ____________________ ______________
NAME SIGNATURE YY/MM/DD

STAFF/CAREGIVER: ____________________ ____________________ ______________
NAME SIGNATURE YY/MM/DD

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DATE CHILD LEAVE THE FACILITY: ______________
YY/MM/DD

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