District of Parry Sound
Social Services Administration Board

CHILD CARE RESOURCES ENROLLMENT FORM

This form is to be completed by parent/guardian and returned to the program prior to admission.

PROGRAM:

Waubeek Early Learning and Child Care Centre ☐
First Steps Early Learning and Child Care Centre ☐
Highlands Early Learning and Child Care Centre ☐
Fairview Early Learning and Child Care Centre ☐
Home Child Care Program (indicate Provider) ☐

Sundridge After School Program ☐
Evergreen After School Program ☐
Fairview After School Program ☐

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CHILD INFORMATION

CHILD'S NAME: (First and Last)		PREFERRED NAME:	
DATE OF BIRTH:		GENDER:	Male ☐ Female ☐

PARENT/GUARDIAN INFORMATION:

Applicant #1		Complete Address: *(eg. street number and name, postal box if applicable, municipality, postal code)*	
Birth Date:			
Relationship to child:	☐ Mother ☐ Father ☐ Guardian ☐ Grandmother ☐ Grandfather ☐ Other:		
Place of Employment/School:		Employment Address:	
Home Phone:		Work #		Cell #	
Email:			
Custody	If there is a legal custody agreement in place, please provide a copy. Yes ☐ No ☐		

Applicant #2 *(if applicable)*		Complete Address: **If different from above.*	
Birth Date:			
Relationship to child:	☐ Mother ☐ Father ☐ Guardian ☐ Grandmother ☐ Grandfather ☐ Other:		
Place of Employment/School:		Employment Address:	
Home Phone:		Work #		Cell #	

EMERGENCY CONTACT INFORMATION: (If Parent/Guardian cannot be reached.)

Name:	Home Phone #:	Work Phone #:	Cell Phone #:	Relationship to child:

CONSENT TO RELEASE: Additional person(s) other than the above that your child may be released to?

NOTE: We will not release your child to anyone not identified on this form. Please notify us in writing whenever anyone else will be picking up your child.

Name:	Contact #:	Relationship to child

Are there any other children or adults in the home?

Name of other adult:	Relationship to child:

Is there anything else that is important to know about your child/family?	

(Revised January 2017)

MEDICAL INFORMATION:

Family Doctor:		Address:		Phone #:	

Please identify any Medical Condition(s) and/or Allergies? *(eg. Anaphylaxis, Asthma, Diabetes, Epilepsy, Food, Environmental, Animals, Bees, etc.)*	Description	Severity	EpiPen/Medication
		☐ High ☐ Medium ☐ Low	☐
		☐ High ☐ Medium ☐ Low	☐
		☐ High ☐ Medium ☐ Low	☐
		☐ High ☐ Medium ☐ Low	☐

***IMPORTANT** – if you've indicated a medical condition and/or allergy (eg. allergic reactions such as respiratory distress, skin irritations, runny eyes, runny nose, fever, etc.) that requires possible treatment, an Emergency Form must be completed and an Emergency Plan created prior to program entry.

Anaphylaxis Emergency Plan ☐ **Emergency Medical Plan ☐**

Are there any Special Diets/Foods to consider? *(eg. Nuts, Dairy, Tofu, Wheat, Gluten, Fruits, Vegetable, etc.)*	Description	Sensitivity	Severity	Cultural
		☐	☐ High ☐ Medium ☐ Low	☐
		☐	☐ High ☐ Medium ☐ Low	☐
		☐	☐ High ☐ Medium ☐ Low	☐
		☐	☐ High ☐ Medium ☐ Low	☐

Please list all communicable diseases your child has had - for example: chicken pox, hepatitis, measles, etc.	

Is your child connected to any of the following supports?	☐ One Kids Place (Speech & Language, Occupational Therapy, Physical Therapy, etc.) ☐ HANDS (Infant Development, Great Beginnings, TIPS, etc.) ☐ Children's Aid Society (CAS) ☐ Ontario Early Years Child & Family Centre ☐ Inclusion Support Services (ISS) ☐ Other:

Are there any significant concerns about your child's development? If yes, please list and explain.	

NOTE: Please ensure we have an updated <u>immunization record</u> for each child.

AUTHORIZATIONS:

MEDICAL EMERGENCY: If the parent/guardian or persons listed under "Emergency Numbers" cannot be reached, then permission is hereby given to Child Care Resources to provide and/or seek medical aid.

ACTIVITIES OFF PREMISES: Part of the program includes outings, for example a walk to the fire station, library, etc, which take the children off the program premises. Your signature provides us with permission to do so. For field trips that require transportation, the program will provide a separate permission form.

The following conditions are to be followed for my child in the above authorizations:	

I hereby authorize the application of sunscreen to my child.

I authorize the release of this information to persons providing care to my child.

I have read, understood and agree to the above. I will notify the appropriate program when there are changes to my situation.

Date: ______________________

Signature: ________________________________ **Witness:**________________________________

For office use only	
Date Enrolled:	Date Discharged:

(Revised January 2017)