District of Parry Sound Social Services Administration Board

CHILDREN'S SERVICES ENROLLMENT AGREEMENT

Appendix-C2

This Enrollment Agreement is between the PSDSSAB-Children's Services and _____to receive child care services
(Parent/Guardian Name)
for _____ at the following program(s):
(Child(ren) Name(s))

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) ☐

I/We understand and agree to comply with the following:

REGISTRATION:

1. To agree with the pre-arranged hours and days of child care, as indicated below:

	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
Drop-off Time							
Pick-up Time							

*Please initial in the space provided where applicable

2. _____ To ensure **ANY** changes to the above days and hours of care have prior approval by the Program Supervisor.
   ***Please note, if you are decreasing the number of days of child care required, the program will do their best to accommodate your space requirements should you need them to change or increase at a later date, however, we cannot make any guarantees that space will be available.**

3. _____ To ensure subsidized child care is only used for the days and hours you are at work or attending school or otherwise approved by the child care fee subsidy office.

4. To advise the program or HCCP provider, as soon as possible, of any unplanned absences and the reasons for the absences.

5. To provide two weeks' notice when a child is being withdrawn from the program or if there is a change in the scheduled days. Failure to provide notice may result in your account being invoiced for this period.

6. To ensure all information on the enrollment and medical forms remain current.

(Revised June 2022)

District of Parry Sound Social Services Administration Board

CHILDREN'S SERVICES ENROLLMENT AGREEMENT

Appendix-C2

PROGRAM:

1. To escort the child safely into the child care program, ensuring the educator/provider is aware of the child's arrival.

2. To ensure the child is always picked up at the agreed upon time or a late pick-up fee of $10 for every 15-minute increment that your child is in attendance beyond the pick-up time indicated on the signed Enrollment Agreement may be charged. Please note, HCCP providers are independent contractors and as such, may charge a different late pick-up fee.

3. The child is only released to persons listed on the Enrollment Form or a Release Form will be completed and signed by the parent/guardian prior to person's not named on the authorization list will be permitted to leave the child care premises with the child.

4. To advise the program of special diets or mealtime concerns for your child and to provide special foods if required (i.e. baby food, formula). Food supplied by parents/guardians must be clearly labeled with child's full name and date of delivery to the child care program.

5. To keep the child at home if they have an infection, fever or illness that could be passed on to others, or if the child is too ill to participate in all aspects of the daily program. Licensed child care programs are required to provide a minimum of 2-hours outdoor play a day (weather permitting) and all children are expected to participate.

6. To comply with other conditions as outlined in the Program Family Guide.

Failure to comply with the above conditions may result in the termination of your child care arrangement.

Families are encouraged to discuss any problems or concerns regarding their child with the Program Supervisor.

Date (dd/mm/yy): _____

Parent / Guardian Signature: _____

(Revised June 2022)

District of Parry Sound Social Services Administration Board

CHILDREN'S SERVICES ENROLLMENT

Appendix-C3

For Office Use Only:
Date of Admission(dd/mm/yy):

Date of Discharge (dd/mm/yy):

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) ☐ _____

CHILD INFORMATION

CHILD'S LEGAL NAME:		CHILD'S COMMON NAME:	
DATE OF BIRTH (dd/mm/yy):		PRONOUN:	
CHILD'S ADDRESS: **If different than Applicant #1**			

PARENT/ LEGAL GUARDIAN INFORMATION:

Applicant #1		Birth Date	
Relationship to child			
Complete Address **Please include mailing address**		Town/Municipality	Postal Code
Phone #		Email	
Place of Employment/School		Work Phone #	
Employment Address		Town/Municipality	Postal Code
Marital Status	☐ Single – **If single, please do not fill out Applicant#2 information** ☐ Married ☐ Common-law		
Parental Agreement **If there is a formal parental agreement, please provide a copy**	Are there Parental Agreements pertaining to the legal right of access to your child? ___ Name of custodial parent/guardian: _____ Name(s) of individuals prohibited from access to your child: _____		

Applicant #2		Birth Date	
Relationship to child			
Complete Address **If different than above**		Town/Municipality	Postal Code
Phone #		Email	

(Revised November 2021)

Place of Employment/School		Work phone #	
Employment Address		Town/Municipality	Postal Code

EMERGENCY CONTACT INFORMATION: In the event of an emergency, if a parent cannot be reached, the following individual(s) may be contacted. Please list in order of preference.

Emergency Contact #1	Emergency Contact #2	Emergency Contact #3
Full Legal Name:	Full Legal Name:	Full Legal Name:
Common Name:	Common Name:	Common Name:
Relationship to Child:	Relationship to Child:	Relationship to Child:
Primary Phone No.:	Primary Phone No.:	Primary Phone No.:
Alternate Phone No.:	Alternate Phone No.:	Alternate Phone No.:
Home Address:	Home Address:	Home Address:
☐ Authorized to pick-up child	☐ Authorized to pick-up child	☐ Authorized to pick-up child

PICK-UP AUTHORIZATION: The following additional individuals are authorized to pick-up my child (Photo ID will be required to confirm identity before the child will be released):

Full Legal Name	Relationship to Child	Primary Phone #

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.

Additional Emergency Information: Please provide any special medical or additional information about your child that could be helpful in an emergency (e.g. known medical conditions, hearing/vision difficulties):

Is there anything else that is important to know about your child/family? (e.g. other children or adults in the home, pets, favorite items)

As part of Integrated Service Delivery please share with us if your family is connected with any of the following:	☐ One Kids Place (Speech/Language, Occupational Physical Therapy, etc.) ☐ HANDS (Infant Development, Great Beginnings, OAP, etc.) ☐ Children's Aid Society (CAS) ☐ EarlyON Child & Family Centre ☐ Inclusion Support Services (ISS) ☐ Other: _____

(Revised November 2021)

MEDICAL INFORMATION:

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

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

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

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

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

AUTHORIZATIONS:

MEDICAL EMERGENCY: If the family or persons listed under "Emergency Contact Information" cannot be reached, then permission is hereby given to The Parry Sound District Social Services Administration Board to provide and/or seek medical aid. *** PLEASE NOTE:** In the event of critical emergency, first responders will be the first point of contact.

ACTIVITIES OFF PREMISES: Part of the program includes community outings, for example walk to the fire station, 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.

I hereby authorize the application of sunscreen, insect repellent, hand sanitizer, or diaper cream if applicable to my child.

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

THE FOLLOWING CONDITIONS ARE TO BE FOLLOWED FOR MY CHILD IN THE IN THE ABOVE AUTHORIZATIONS:_____

_____

_____

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

Parent/Guardian Signature: _____ Date (dd/mm/yy): _____

Agency Signature: _____ Date (dd/mm/yy): _____

(Revised November 2021)

District of Parry Sound Social Services Administration Board

DIRECTLY OPERATED CHILD CARE PROGRAMS FINANCIAL AGREEMENT

Appendix-C4

This Financial Agreement is between the District of Parry Sound Social Services Administration Board

and

_____

(Parent/Guardian Name)

to receive child care services from

_____

(Program Name)

for

_____

(Child's Name/Children's Names)

I understand and agree to comply with the following statements.

Please initial

1. Upon enrollment or at any point in which child care fees apply, I am responsible for selecting my method of payment in the HiMama billing platform (HiMama). _____

2. I will turn autopay on, and keep autopay turned on in HiMama to pay for my child care services on a monthly basis, and I am able to change my payment details in HiMama as needed. _____

3. I am responsible to pay for all scheduled days of child care as indicated on my signed Enrollment Agreement. _____

4. I will have access, and can review my monthly invoice in HiMama on the first day of each month (or the next operational day if the 1st is on a weekend/holiday). I will contact my child care program immediately to discuss any observed discrepancies. _____

5. My monthly invoice is due to be paid on the **8th day** of each month. I will ensure adequate funds are available by this date as these funds will automatically be withdrawn from my selected method of payment (bank account or credit card). _____

6. I am in full control of my payments and payment setting, and I will notify my child care program immediately if at any time I need to turn autopay off. _____

7. A late pick-up fee of $10 will apply for every 15-minute increment that your child is in attendance beyond the pick-up time indicated on my signed Enrollment Agreement. _____

8. An additional $25.00 fee will be applied for Non-Sufficient Funds (NSF). As payments are due to be paid on the 8th day of each month, failure to pay will result in an immediate child care suspension. _____

_____	_____	_____
Parent/Guardian – Print Name	Signature	Date (d/m/y)
_____	_____	_____
Program Supervisor – Print Name	Signature	Date (d/m/y)

Vaccination History for Childcare Registration

☐ Initial Assessment ☐ Updated Information

Under the Childcare and Early Years Act, 2014, Reg 137/15, the operator of a licensed childcare facility is required to ensure that all infants and children admitted to a childcare facility meet one of the following options:

1. Is fully immunized as recommended by the local Medical Officer of Health
2. Has documentation in writing in the form of a Medical Exemption on file with the Health Unit
3. Has documentation in writing in the form of a Statement of Religious or Conscience Statement on file with the Health Unit

Parents / guardiansare asked to complete ***all of the information in Section 1*** of this form. Please **attach a copy of your child's vaccination record** if they have received their vaccinations anywhere other than the Health Unit. Please ensure your child's full name and date of birth are on both documents. Completed forms and a copy of your child's vaccination record if appropriate, are to be returned to the childcare facility for submission to the Health Unit. **The Health Unit will only accept and process forms submitted by the childcare facility.**

Each year, your childcare facility will provide a list of all the children registered at the childcare facility who do not attend school to the Health Unit for review to confirm their vaccinations remain up to date. If your child's vaccinations are not up to date at the time of that assessment, the childcare facility will be notified and you will be asked to contact the Health Unit for further information. The childcare facility will not be told what information is missing.

SECTION 1 – to be completed by the parent/guardian – please complete all information requested legibly and fully.

Date completed: _____ Name of Childcare Facility & Site: _____

Child's Name _____ Date of Birth _____
First Name Last Name(s) YYYY/MM/DD

Child's Health Card Number _____ Has your child received their vaccinations at the health unit:
☐ Yes ☐ No

Address _____ PO Box _____ RR#_____ Site _____ Apt # _____

City/Town _____ Prov. _____ Postal Code _____

Parent/Guardian's Name(s)_____

Home # _____ Work # _____ Cell # _____

Section 2 - to be completed by the Childcare Facility Supervisor

I have reviewed the information provided on this form for completeness and accuracy and ensured a copy of the child's vaccination record is included if required.

Date: _____ Supervisor's Signature: _____

Section 3 - For Health Unit Use Only

☐ Immunization record up to date
☐ Immunization record **NOT** up to date – direct parent / guardian to contact the Health Unit at 705-474-1400 ext 5252 or via email at vpd@healthunit.ca
☐ Appropriate documentation on file

Next immunization due at: ☐ 12 months of age ☐ 15 months of age ☐ 18 months of age ☐ 4-6 years of age
☐ other _____

Signature of Nurse _____ Date & Time _____
YYYY/MM/DD

revised September 2019