

**Name of Facility:**

CHILD'S START DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
YY MM DD

SEX: M \_\_\_\_ F \_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_  
YY MM DD

NAME OF CHILD: \_\_\_\_\_  
(Surname) (Given Names) (Also Known As)

Name the child responds to: \_\_\_\_\_

Address: \_\_\_\_\_

Postal code: \_\_\_\_\_ Phone: \_\_\_\_\_

Person(s) with whom the child lives (adults and children): \_\_\_\_\_

Child's first language: \_\_\_\_\_ Other languages: \_\_\_\_\_

**Parent(s) / guardian(s):**

Name: \_\_\_\_\_ Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Days/hours of work: \_\_\_\_\_ E-mail: \_\_\_\_\_

Name: \_\_\_\_\_ Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Days/hours of work: \_\_\_\_\_ E-mail: \_\_\_\_\_

**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):**

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

**If appropriate, list an English speaking contact:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Has the child previously attended davcare/preschool?**

YES  NO  Comments: \_\_\_\_\_

**Comments/instructions to help us care for your child. (Please feel free to add additional pages.):**

Toileting/Diapering (special words): \_\_\_\_\_

Rest time (special comfort – toy/blanket): \_\_\_\_\_

Eating/Mealtime (include food likes/dislikes): \_\_\_\_\_

Fears: \_\_\_\_\_

Please tell us anything else you think will help us provide an enriching experience for your child: \_\_\_\_\_

**HEALTH INFORMATION**

Health professionals involved with your child (other than doctor and dentist):

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: \_\_\_\_\_

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 a 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	Reason for Medication
_____	_____	_____
_____	_____	_____

You may be asked to complete additional forms if you answered yes to any of the above.

The above health information may be made available to the staff of Vancouver Coastal Health.

Custody Agreement YES  N/A  Provided to Facility YES  NO  N/A

Photocopy of Immunization Records Provided to the Facility YES  NO

**Parent/Guardian:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Name Signature YY MM DD

**Staff/Caregiver:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Name Signature YY MM DD

<p><b>Office Use Only</b></p> <p>Date child leaves the facility: _____ / _____ / _____ YY MM DD</p>
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