CHILD'S STARTING DATE: SEX: DATE OF BIRTH: M ____ F ___ YY MM I NAME OF CHILD: __ (Surname) (Given Names) (Also Known As) Name the Child responds to: ___ Phone: Postal code: ____ Person(s) with whom the child lives (adults and children): Child's first language: _____ Other languages: _____ Parent(s) / guardian(s): _____ Home phone: _____ Cell phone: _____ Name: Work phone: ______ Days/hours of work: _____ E-mail: _____ ______ Home phone: ______ Cell phone: ______ _____ Days/hours of work: ______ E-mail: _____ Work phone: _____ 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): _____Relationship to child: ____ Work phone: _____ ____ Cell phone: ___ Home phone: ___ ___ Relationship to child: ___ Work phone: _____ Cell phone: _____ Home phone: ____ Name: ______ Relationship to child: _____ Home phone: ______ Work phone: _____ Cell phone: _____ ______Relationship to child: ____ Name: ___ _____ Work phone: _____ Home 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: _

Name of Facility:

CCFI 2 09-09

Please tell us anything else you think wil	l help us provide an enriching experier	nce for your child:
HEALTH INFORMATION		
Health professionals involved with your child (other than doctor and dentist):	
NAME	PROFESSION/AGENCY	Phone:
		TV.
		Phone:
Does your child have:		
A medical condition/concern? If yes, please provide further information:	YES NO	
Allergies? If yes, please provide further information:	YES NO	
Asthma? If yes, please provide further information:	YES NO	
Has your child had a seizure in the past year? If yes, please provide further information:		
Does your child require a special diet related to If yes, please provide further information:		
Food sensitivities? If yes, please provide further information:	YES NO	
List all prescription and "over the count	er" medications your child receives:	
Medication	Times Given	Reason for Medication
You may be asked to complete additiona This health information may be made av		
Custody Agreement YES □ N/A □ Immunization Documents Returned to		YES \square NO \square N/A \square
Information Provided By:	Print Name	Signature
DATE://	Timervanie	Signature
Information Received By:	Print Name	Ciamatuma
DATE://	Print Name	Signature
Office Use Only Date Child Leaves the Facility: DATE:	· /_ /	
,	YY MM DD	

CHILD CARE

CCFL3, Rev 04-2009

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EMERGENCY CONSENT FORM

Please attach child's photo to this form.

CHILD'S NAM	ЛЕ:	BIRTHD	ATE: YEAR/MONTH/DAY	
	SURNAME		YEAR/MONTH/DAY	
PARENT'S N	AME:	HOME PHO	ONE:	
CELL PHONE:		WORK PHO	WORK PHONE:	
PARENT'S NAME:		HOME PHO	HOME PHONE:	
CELL PHONE:		WORK PHO	ONE:	
EMERGENCY	Y CONTACT:	CELL PHONE:	PHONE:	
OUT OF TOW	F TOWN CONTACT: PHONE:		ONE:	
CHILD'S DOC	CTOR:	PH	IONE:	
DATE OF MC	ST RECENT TETANUS SHO	OT:		
ALLERGIES /	MEDICATIONS:			
CHILD'S DEN	'S DENTIST: PHONE:		IONE:	
		<u>CONSENT</u>		
1)			a parent when a child is ill or needs medical attention. Occasionally we to get immediate help for the child. Our procedure is to call for an	
2)		ease sign the consent below so that we can take the appropriate action on behalf of your child. Return the uned consent to the facility immediately. We will take this consent with us to the emergency centre.		
3)	I hereby give consent for my cl the nearest emergency centre	y child to be taken to tre when I cannot be contacted.		
4)	I hereby give consent for my c	hild named above to receive medical treatment.		
_	DATE	SIGNATURE OF PAR	ENT / GUARDIAN	
		WITNESS		

Provided by VCH – Community Care Facilities Licensing