



# THE CHILDREN'S CENTRE

at Duncan Elementary

## Child Registration Form

A \$250.00 deposit is required to secure a space for your child and can be used for the first month in the centre or refunded after three months minus any outstanding penalties.

<b>*Child Information</b>		
First Name	Last Name	
Birthday (Year/Month/Day)	Gender	
<b>*Child's Address</b>		
Street1		
Street2		
City	Province	Postal Code

<b>*Parent/Guardian Information (Primary)</b>		
First Name	Last Name	
Relationship to Child	Phone Number	
Email	Alternate Number	
Place of Work	Hours of Work	
<b>*Address (Primary)</b>		
Street1		
Street2		
City	Province	Postal Code

<b>*Parent/Guardian Information (Secondary)</b>		
First Name	Last Name	
Relationship to Child	Phone Number	
Email	Alternate Number	
Place of Work	Hours of Work	

<b>Address (Secondary)</b> *If applicable.		
Street1		
Street2		
City	Province	Postal Code

<b>*Enrollment Information</b>	
Desired Start Date (Year/Month/Day)	
<b>Office Use Only</b> Start Date (Year/Month/Day)	End Date (Year/Month/Day)

<b>Approved Pick-up and Drop-off Contacts</b>		
<b>Name</b>	<b>Relationship</b>	<b>Phone Number</b>
*1.		
*2.		
*3.		
4.		
5.		
6.		

***\*Please provide a minimum of 3 contacts for emergency purposes. Photo ID is required at pick-up.***

**Custody Matters**

Are there custody orders? If yes, please attach documentation.  Yes  No

**Persons Not Permitted to Access Child**

Name	Relationship	Phone Number

**About Your Child**

Does your child have experience away from home? (Daycare, preschool, Sunday school, etc.)

Does your child feel comfortable leaving parents?

<b>Medical Information</b>	
Doctor	Phone Number
*MSP #	
Known health or medical conditions?	
Has your child had a recent illness?	
List any communicable disease your child has had.	
Does your child have any allergies? Please provide any important information or instructions ( <b>See Allergy Report Form</b> ) and attach doctor's note if applicable.	
*Has your child been immunized? If yes, please provide supporting documentation. If no, please fill out the <b>Immunization Form</b> below. <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Immunization Form</b>
<p>In support of Public Health and ongoing prevention, The Children's Centre encourages routine childhood vaccinations.</p> <p><input type="checkbox"/> I have chosen not to immunize my child.</p> <p><input type="checkbox"/> I am pursuing immunizations for my child.</p>

## Immunization Form Agreement

I understand and agree to keep my child at home during illnesses that are identified by Public Health as being a risk to children. I also understand that I will be required to take my child to a health practitioner for assessment when symptoms displayed may be those of illnesses which my child has not been immunized against. A health practitioner's note stating that my child is not contagious will be required to return to the centre.

Parent or Guardian Name

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Parent or Guardian Signature

Date (Year/Month/Day)

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## Child Immunization Schedule

First Visit — two months of age:	Fourth Visit — 12 months of age:
	Pneumococcal Conjugate
<b>Diphtheria</b>	Measles
Pertussis	Mumps
Tetanus	Rubella
<b>Polio</b>	Meningococcal C Conjugate
Haemophilus Influenza Type b (hib)	Varitella (chicken pox)
Hepatitis B	
Pneumococcal Conjugate	Fifth Visit — 12 months after third visit:
Meningococcal C Conjugate	Diphtheria
Rotavirus	Pertussis
	Tetanus
Second Visit — two months after first visit:	Polio
Diphtheria	Haemophilus Influenza Type b (hib)
Pertussis	
Tetanus	4 to 6 years of age:
Polio	Diphtheria
Haemophilus Influenza Type b (hib)	Pertussis
Hepatitis B	Tetanus
Pneumococcal Conjugate	Polio
Rotavirus	Varicella (chicken pox)
Third Visit — two months after second visit:	Measles
Diphtheria	Mumps
Pertussis	Rubella
Tetanus	Other Immunizations:
Polio	COVID-19 — 1 <sup>st</sup> Dose
Haemophilus Influenza Type b (hib)	COVID-19 — 2 <sup>nd</sup> Dose
Hepatitis B	<b>COVID-19</b> — 3 <sup>rd</sup> Dose
Rotavirus	

## Medical Information Release

By my signature below, I acknowledge the following:

I \_\_\_\_\_ agree to allow The Children's Centre to disclose pertinent information about my child's health condition, health information, and health history in the event of a medical emergency, if I cannot be contacted immediately. A medical practitioner or ambulance will be called in case of accident or illness and all expenses will be paid by the parent or guardian of the child.

Parent or Guardian Signature

Date (Year/Month/Day)

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