

Name of Facility: Creatively Crafted Childcare – The Chill Zone @ Quilchena

CHILD'S START DATE:

SEX:

DATE OF BIRTH:

____/____/____
YY MM DD

M ____ F ____

____/____/____
YY MM DD

NAME OF CHILD: _____

(Surname)

(Given Names)

(Also Known As)

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: _____ E-mail: _____

Name: _____ Home phone: _____ Cell phone: _____

Work phone: _____ 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. (DO NOT include mother / father / guardian):

Name: _____ Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Name: _____ Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

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. _____

Epi Pen? Yes No

If yes, we will request to have one kept at our classroom.

If one has been provided to the school, unfortunately, we will not have access to it in the case of an emergency.

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 have any food sensitivities? Yes No

If yes, please provide further information. _____

You may be asked to complete additional forms if you answered yes to any of the above. This health information may be made available to the staff of Vancouver Coastal Health.

Custody Agreement	YES	NO	N/A	Provided to Facility	YES	NO	N/A
Immunization Documents Given to Facility			YES	NO			
This health information may be made available to the staff of Vancouver Coastal Health.							

<u>Office Use Only</u>
Date Child Leaves the Facility: DATE: _____ / _____ / _____ YY MM DD