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

CHILD'S START DATE: **SEX:** **DATE OF BIRTH:**

______/______/_______ **M ____F ____** **______/______/_______**

YY MM DD **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.

Office Use Only

Date Child Leaves the Facility: DATE:______/______/______

YY MM DD