**S.S Child Care Centre Ltd.**

# Shining Star Child Care Centre

## *Registration Form*

Name of Child _____

Name Used to Address Child _____

Date of Birth _____ Sex _____ Date of Enrollment in Program_____

Full Name of Parent/Guardian (Father)_____

Full Name of Parent/Guardian (Mother)_____

Address (Father)_____ (Mother)_____

Telephone Number: (*Home*) (Father)_____ (Mother)_____

Telephone Number: (*Work*) (Father)_____ (Mother_____

Telephone Number: (*Cell)* (Father)_____ (Mother)_____

Place of Work (Father)_____ (Mother)_____

Hours (Father)_____ (Mother)_____

Care Card Number _____ Email_____

Family Doctor _____ Telephone Number _____

**If a Parent or Guardian cannot be reached person(s) to be notified in case of emergency:**

Name _____ Phone No. (*H*) _____ (*W*) _____

Name _____ Phone No. (*H*) _____ (*W*) _____

| **Persons authorized to pick up your child:** | Phone No. | Relationship |
|---|---|---|
| Name _____ | _____ | _____ |
| Name _____ | _____ | _____ |
| Name _____ | _____ | _____ |
| Name _____ | _____ | _____ |
| Name _____ | _____ | _____ |

**Persons not permitted access to your child:** _____

Custody Restrictions: Yes ☐ No ☐. If yes, please attach court documents and state conditions.

_____

**In order for us to get to know your child better we would really appreciate the following information**:

Names of brothers and sisters and their ages _____

_____

Anyone else living in the home?_____

Pets and their names? _____

Feels good about leaving Mom or Dad?_____

Any previous group experience? _____

Religious or ethnic observances _____

## Health History

Has your child any known health problems _____

_____

List communicable diseases child has had:_____

Does your child wear any medical or dental appliances such as eye glasses, braces, hearing aids, etc.? Please list and explain their use _____

_____

Has your child any allergies?_____

If yes, list allergens: _____

Is your child on any medication?_____

If yes, please specify:_____

| **Name of Drug** | **Condition for Which Prescribed** | **Dosage and Times** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Basic Schedule and Record of Immunization as submitted by Parent or Guardian**
**(ATTACH IMMUNIZATION RECORD OR RECORD THE DATES)**

| | Date (yy/mm/dd) | | Date (yy/mm/dd) |
|---|---|---|---|
| 1st visit - 2 months of age: | | 4th visit - 12 months of age: | |
| G Diptheria | _____ | G Measles | _____ |
| G Pertussis | _____ | G Mumps | _____ |
| G Tetanus | _____ | G Rubella | _____ |
| G Polio | _____ | | |
| G Haemophilus Influenza Type b (Hib) | _____ | 5th visit - 12 months after 3rd visit: | |
| G Hepatitis B | _____ | G Diptheria | _____ |
| | | G Pertussis | _____ |
| 2nd visit - 2 months after 1st visit: | | G Tetanus | _____ |
| G Diptheria | _____ | G Polio | _____ |
| G Pertussis | _____ | G Haemophilus Influenza Type b (Hib) | _____ |
| G Tetanus | _____ | G Measles, Mumps, Rubella | _____ |
| G Polio | _____ | | |
| G Haemophilus Influenza Type b (Hib) | _____ | 4 - 6 years of age: | |
| G Hepatitis B | _____ | G Diptheria | _____ |
| | | G Pertussis | _____ |
| 3rd visit - 2 months after 2nd visit: | | G Tetanus | _____ |
| G Diptheria | _____ | G Polio | _____ |
| G Pertussis | _____ | | |
| G Tetanus | _____ | Other Immunizations: | |
| G Polio | _____ | _____ | |
| G Haemophilus Influenza Type b (Hib) | _____ | _____ | |
| G Hepatitis B | _____ | _____ | |

I, the parent/guardian of this child hereby authorize S.S Child Care Centre Ltd. staff to call a medical practitioner or ambulance in the event of an emergency.

_____ _____

Signature of Parent/Guardian Date