Fraser Health AUTHORITY

REGISTRATION FORM FOR CHILD CARE

Facility Name:	
Full Name of Child:	Alias:

Personal Information		
Child's Date of Birth:	Gender:	Starting Date:
Address:	Postal Code:	
	Phone:	
Parent or Guardian	Parent or Guardian	
Address [if different from the above]	Address [if different from the above]	
Phone:	Phone:	
Work Address/Alternate Location	Work Address/Alternate Location	
Cell/Pager:	Cell/Pager:	
Hours at this location:	Hours at this location:	

Emergency Health Information	
Care Card Number:	
Family Doctor/Clinic Name:	Family Dentist:
Address/Phone:	Address/Phone:

Consent For Emergency Care	
I Authorize the staff at the child care center to contact a medical practitioner or ambulance in the case of accident or illness of my child(ren), if the parent cannot immediately be reached.	
Signature of Parent/Guardian:	Date:
Manager of Facility:	

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ADMINISTRATION OF MEDICATION CONSENT FORM

CHILD'S NAME:		
PHYSICIAN'S NAME:		PHONE:
PHARMACY NAME:		PHONE:
MEDICATION:		PRESCRIPTION#:
DOSAGE OF MEDICATION:	HAS THIS MEDICATION BEEN ADMINISTERED TO THE CHILD PREVIOUSLY? ◯ YES ◯ NO IF NO, HAS CHILD RECEIVED MEDICATION FOR 24 HOURS PRIOR TO RETURNING TO THE CHILD CARE PROGRAM? ◯ YES ◯ NO	
TIMES TO BE GIVEN BY PARENT:		
TIMES TO BE GIVEN BY CAREGIVER:		
ANY POSSIBLE SIDE EFFECTS THAT YOU HAVE BEEN MADE AWARE OF BY THE PHYSICIAN OR PHARMACY?		

I HEREBY GIVE PERMISSION AND AUTHORIZE THE STAFF OF BARNEY FAMILY DAYCARE INC. TO ADMINISTER THE MEDICATION IN THE DOSAGE AS STATED ABOVE. THIS DOSAGE IS CONSISTENT WITH THE RECOMMENDATIONS OF THE PHYSICIAN AND/OR THE DRUG MANUFACTURER. I ACCEPT THE RESPONSIBILITY OF SUPPLYING THE CURRENT CORRECT MEDICATION IN ITS ORIGINAL CONTAINER, AND I AGREE TO SUBMIT A NEW CONSENT FORM, IF THERE IS ANY CHANGE IN THE MEDICATION TO BE ADMINISTERED.

______________________________ ______________________ ______________________

SIGNATURE OF PARENT/GUARDIAN DATE PHONE

CAREGIVER'S ADMINISTRATION RECORD

DATE	TIME GIVEN	AMOUNT GIVEN	ADMINISTERED BY

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PERSON(S) AUTHORIZED TO PICKUP CHILD (OTHER THAN PARENTS / GUARDIANS LISTED ABOVE)		
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

PERSON(S) NOT AUTHORIZED TO PICKUP CHILD		
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

CUSTODY AGREEMENT:	◯ **YES** ◯ **NO**
IF YES, SUPPLY A COPY OF THE CUSTODY ORDER TO THE FACILITY MANAGER/LICENSEE	

ALTERNATE PERSON(S) TO CALL AND PICKUP CHILD IN CASE OF EMERGENCY		
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

CHILD'S IMMUNIZATION STATUS					
IS YOUR CHILD IMMUNISED:			◯ YES ◯ NO		
DIPHTHERIA	PERTUSSIS	TETANUS	POLIO	MMR	HIB
1.	1.	1.	1.	1.	1.
2.	2.	2.	2.	2.	2.
3.	3.	3.	3.		
4.	4.	4.	4.		
5.	5.	5.	5.		

COMMENTS:

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ADDITIONAL CHILD HISTORY

(OPTIONAL)

EATING AND NUTRITION		
LIST YOUR CHILD'S FAVOURITE FOOD:		
LIST ANY DISLIKED FOOD:		
PLEASE DESCRIBE ANY PARTICULAR PATTERNS:		
ARE THERE ANY RELIGIOUS ETHNIC OBSERVANCES TO FOODS:		
SLEEPING		
NAP TIME:	HOW LONG TO SETTLE:	TIME OF WAKING:
BED TIME:	HOW LONG TO SETTLE:	TIME OF WAKING:
IS YOUR CHILD A DEEP SLEEPERS, OR DOES (S) AWAKEN EASILY?		
DOES YOUR CHILD TAKE A FAOURITE COMFORTER {E.G. BLANKET OR TOY} TO BED? ◯ YES ◯NO IF YES, PLEASE DESCRIBE AND TELL US IF IT IS "NAMED"?		
WHAT IS YOUR CHILD'S MOOD UPON WAKEINIG?		
TOILETING		
IS YOUR CHILD TOILET-TRAINED? ◯YES ◯ NO ◯PARTITALLY		
PLEASE INDICATE YOUR CHILD'S FREQUENCY OR PATTERNS FOR BOWEL MOVEMENTS:		
DESCRIBE ASSISTANCE NEEDED FOR TOILETING:		
WHAT "SPECIAL" WORD DOES YOUR CHILD USE FOR: URINATION ____________________ BOWEL MOVEMENT__________________________ OTHER____		

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FAMILY AND GENERAL HOUSEHOLD INFORMATION

<table>
<tr><td colspan="2">PLEASE LIST THE NAMES OF THE SIGNIFICANT PEOPLE IN YOUR CHILD'S LIFE [E.G.: SIBLINGS, GRANDPARENTS, ETC.]:</td></tr>
<tr><td colspan="2">PLEASE DESCRIPE THE GUIDANCE AND DICIPLINE METHODS USED AT HOME:</td></tr>
<tr><td>PRIMARY LANGUAGE SPOKEN AT HOME:</td><td>OTHER LANGUAGES:</td></tr>
<tr><td>NAME OF ENGLISH SPEAKING PERSON [IF NEEDED]:</td><td>PHONE:</td></tr>
</table>

ANY OTHER COMMENTS

SIGNATURE OF PARENT OR GUARDIAN PROVIDING THE INFORMATION		
SIGNATURE	PRINT NAME	DATE

NOTE: THIS INFORMATION MAY BE REVIEWED BYFRASER HEALTH AUTHORITY LICENSING STAFF AS PER LEGISLATION.

<table>
<tr><th colspan="3">FACILITY USE ONLY</th></tr>
<tr><td colspan="3">STAFF PERSON REVIEWING FAMILY'S DOCUMENTS:</td></tr>
<tr><td>SIGNATURE:</td><td>PRINT NAME:</td><td>DATE:</td></tr>
<tr><td>CHILD'S WITHDRAWAL DATE:</td><td colspan="2">REASON FOR WITHDRAWAL:</td></tr>
</table>