

# SHINE-SIGN



## REGISTRATION FORM

Child's Last Name \_\_\_\_\_ Child's First Name \_\_\_\_\_

Birth Date(day/month/year) \_\_\_\_\_ Age \_\_\_\_ Grade \_\_\_\_ M/F \_\_\_\_\_

Home Address \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ Start Date: \_\_\_\_\_

Type of Service (full time/part time/other) \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Mother's Cell \_\_\_\_\_ Father's Cell \_\_\_\_\_

Mothers home phone \_\_\_\_\_ Father's home phone \_\_\_\_\_

Mother's Place of Work \_\_\_\_\_ Father's Place of Work \_\_\_\_\_

Mother's Work Phone # \_\_\_\_\_ Father's Work Phone # \_\_\_\_\_

E-mail: \_\_\_\_\_ (please print clearly)

Emergency Contacts (please list people who are readily available and live close by)

\_\_\_\_\_ Phone Number \_\_\_\_\_

\_\_\_\_\_ Phone Number \_\_\_\_\_

Name(s) of person(s) designated to pick up child \_\_\_\_\_

Number of children at home \_\_\_\_\_ Ages \_\_\_\_\_

Other languages spoken/understood by child \_\_\_\_\_

Has child had previous experience away from home? \_\_\_\_\_

If "Yes" where, for how long \_\_\_\_\_

How did you hear about our Centre? a) informed by friend b) newspaper add c) website

Child's Doctor \_\_\_\_\_ Phone Number \_\_\_\_\_

B.C. Medical Number \_\_\_\_\_

Has this child had any known physical/mental health problem? Yes No

If "Yes" please describe or write the diagnosis:

\_\_\_\_\_

Does the child have any allergies? \_\_\_\_\_ If "Yes" list materials or products concerned:

\_\_\_\_\_

Please list any special instructions regarding food and materials to avoid, or any procedures to follow in the case of an allergic reaction. \_\_\_\_\_

Please help us to support multiculturalism in our Centre by letting us know about your values.

What are the most important cultural, religious or traditional celebrations for your family?

1.Date (day/month/) \_\_\_\_\_ Celebration name: \_\_\_\_\_

2.Date (day/month/) \_\_\_\_\_ Celebration name: \_\_\_\_\_

3.Date (day/month/) \_\_\_\_\_ Celebration name: \_\_\_\_\_

Record of Immunization      1<sup>st</sup> Dose      2<sup>nd</sup> Dose      3<sup>rd</sup> Dose      4<sup>th</sup> Dose

Diphtheria/Pertussic/Tetanus \_\_\_\_\_

Poliomyelitis \_\_\_\_\_

M/M/R. (Combined) \_\_\_\_\_

Hib \_\_\_\_\_

## **CONSENT FOR EMERGENCY CARE**

I authorize the staff at the SHINE-SIGN childcare centre to call a medical practitioner or ambulance in the case of accident or illness of child, if the parent cannot immediately be reached.

I agree that my child will not be released to anyone not designated on this form. I understand that SHINE-SIGN childcare centre is not equipped to care for sick children and I will be contacted and asked to come and pick up my child should he/she become ill during the day.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_