

A BRIGHT BEGINNING SCHOOL AGE CARE ENROLMENT FORM

Requested Start Date: _____ Actual Start _____	Date of Birth _____ Age _____
Child's Name: _____	Child's Primary address _____ PC ____ ____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Siblings _____	_____ Health Care # (Required): Prov. _____

Hours of Care Needed:	<input type="checkbox"/> Full-time (am, pm, non-School days) <i>Schedule will be required monthly</i>	<input type="checkbox"/> AM only <i>Schedule will be required monthly</i>	<input type="checkbox"/> After School only <i>Schedule will be required monthly</i>
School attending _____	Teacher _____	Grade _____	
Drop Off Time _____	Info: _____		
Pick-Up Time _____			

Parent or Legal Guardian Information	
Mother (or Guardian 1) Information	Father (or Guardian 2) Information
Name: _____	Name: _____
Home Address: _____ PC _____	Home Address: _____ PC _____
Contact Phone: _____	Contact Phone: _____
Cell Phone: _____	Cell Phone: _____
Place of Employment: _____	Place of Employment: _____
Work Phone: _____	Work Phone: _____
Email Address: _____	Email Address: _____

Emergency Contact	Health
Name:	Allergies or special Dietary needs <input type="checkbox"/> no <input type="checkbox"/> yes give brief description
Relationship:	
Address(required):	Health issues or conditions <input type="checkbox"/> no <input type="checkbox"/> yes give brief description
Home Number:	
Cell Number:	Family Doctor/Clinic Phone number
Work Number:	Immunized <input type="checkbox"/> Yes <input type="checkbox"/> No

Any other information

FOIP Statement
Information gathered is used sole for the purpose of the Centre and it's staff, to place the child at the Centre

It is the parent's responsibility to periodically contact the Centre to insure that child's name remains on the wait list. Please call actively to update information on hours of care needed and changes to contact information. Your contact dates will be recorded. In the event that there is no contacts made for 3 months child's name will be removed from the wait list. Call actively if this Centre is for you. Thank you.

Signature of Parent or Guardian:	Date:
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Log in calls with dates (office use)

Enrollment Information	
Child's Name	Date of Birth
Start Date	Attendance

Medical Information	
Child's Doctor's Name:	Doctor's Phone Number:
Allergies or Special Needs:	
Medication taken on a regular basis and medical condition for which it is taken:	
Immunization Up to Date? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Last Immunization:

History of Illness / Medical History			
Has your child had any of the following illnesses? Please check (<input checked="" type="checkbox"/>)			
<input type="checkbox"/> Mumps	<input type="checkbox"/> Measles (red)	<input type="checkbox"/> Measles (German)	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Frequent Colds
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Croup	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Asthma
<input type="checkbox"/> Eczema	<input type="checkbox"/> Frequent Earaches	<input type="checkbox"/> Injuries*	<input type="checkbox"/> Other*
* Please Describe:			
Does your child have any congenital deformities?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes, Please Comment:			
Are there any restrictions on the kind and/or amount of physical activity your child may participate in?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please comment:			
Has your child undergone surgery?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please comment:			

Are there any special diets or foods necessary for your child's health? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please discuss and note necessary information:	
Does your child have any birthmarks <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe:	
Social Information	
Names and Ages of Brothers and Sisters:	
Name:	Age:
Name:	Age:
Marital Status of Mother (Guardian 1):	Languages spoken at home
Marital Status of Father (Guardian 2):	
Does Your Child Have a Nickname? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Nickname:	
Other persons that can remove child from Centre	
_____ contact # _____	
_____ contact # _____	
_____ contact # _____	
Access Restrictions – Please name anyone NOT allowed to access your child	

Food & Care Needs	
Foods your child likes:	
Foods your child dislikes:	
Foods you do not permit:	
If child has bottle does he/she need/have for nap?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a preference in diaper	<input type="checkbox"/> cloth <input type="checkbox"/> disposable brand _____
Is your child completely trained?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child need help?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Discuss the area of toilet training and note any necessary information as to bathroom routines, training procedures, or reinforcement.

Does your child need help dressing? Yes No child under 3years

If yes, what kind of help is needed?

Does your child have any fears, problems, or concerns with sleeping times? Yes No

Discuss and note necessary information.

Does your child have any problems or concerns with nap time or rest time Yes No

Play

Most of the time does your child prefer:

Playing by him/herself Playing with older children

Playing with own age Being with adults

Playing with younger children No preference

Does your child have any imaginary playmates? Yes No

Please discuss and comment:

Does your child enjoy:

Indoor Play? Yes No
 Outdoor Play? Yes No
 Active Play? Yes No
 Quiet Play? Yes No

What kind of play does your child really enjoy?

Is there anything about the way your child shows affection, anger, or fear that the child care staff should know? Please comment.

Is your child shy?

Yes No Sometimes

With Whom?

When?

Of what is your child afraid?

Does your child have a favourite toy, blanket or soother that he/she could bring to the child care centre?

What characteristics in your child development would you like:

Encouraged?

Discouraged?

Please discuss in detail any information relating to the child that would be helpful to the staff of the child care centre in understanding and caring for the child. Please note any comments and information.

Date Form completed ____/____/____

Signature _____