

A BRIGHT BEGINNING CHILD CARE CENTRE ENROLMENT FORM

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

Hours of Care Needed:	<input type="checkbox"/> Full Time	<input type="checkbox"/> Regular Part Time <small><i>Schedule will be required monthly</i></small>	<input type="checkbox"/> Drop In / Casual
	Monday	Tuesday	Wednesday
	Thursday	Friday	
Drop Off Time			
Pick-Up Time			

Parent or Legal Guardian Information	
Mother (or Guardian 1) Information	Father (or Guardian 2) Information
Name:	Name:
Home Address/land location #	Home Address/land location#
Postal Code	Postal code
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Place of Employment:	Place of Employment:
Work Phone:	Work Phone:
Email Address this will be used for Center reminders and newsletters, and invoicing	Email Address: this will be used for Center reminders and newsletters, and invoicing

Emergency Contact	Health
Name:	Allergies or special Dietary needs <input type="checkbox"/> no <input type="checkbox"/> yes give brief description
Relationship:	
Address street or land location#	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 and just to let us know you still would like a space with us. Your contact dates will be recorded. In the event that there has been no contact made in a 3 month period, the 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:
----------------------------------	-------

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 _____