Vancouver CoastalHealth
Promoting wellness. Ensuring care.

CHILD CARE FACILITIES REGISTRATION FORM

CHILD'S STARTING DATE: _____/_____/_____ **YY MM DD**

DATE OF BIRTH: _____/_____/_____ **YY MM DD**

SEX: M___ F___

NAME OF CHILD: _____ **[SURNAME]** _____ **[GIVEN NAMES]** _____ **[ALSO KNOWN AS]**

NAME THE CHILD RESPONDS TO: _____

ADDRESS: _____

POSTAL CODE: _____ PHONE: _____

PERSON(S) WITH WHOM THE CHILD LIVES [ADULTS AND CHILDREN: _____

CHILD'S FIRST LANGUAGE: _____ OTHER LANGUAGES: _____

PARENT(S)/GUARDIAN(S):

NAME: _____ HOME PHONE: _____

WORK PHONE: _____ DAYS/HOURS OF WORK: _____

NAME: _____ HOME PHONE: _____

WORK PHONE: _____ DAYS/HOURS OF WORK: _____

PERSON(S) AUTHORIZED TO PICK UP THE CHILD AND/OR BE CONTACTED IN CASE OF EMERGENCY [INCLUDE MOTHER/FATHER/GUARDIAN]:

NAME: _____ RELATIONSHIP TO CHILD: _____

HOME PHONE: _____ WORK PHONE: _____

NAME: _____ RELATIONSHIP TO CHILD: _____

HOME PHONE: _____ WORK PHONE: _____

NAME: _____ RELATIONSHIP TO CHILD: _____

HOME PHONE: _____ WORK PHONE: _____

NAME: _____ RELATIONSHIP TO CHILD: _____

HOME PHONE: _____ WORK PHONE: _____

IF APPROPRIATE, AN ENGLISH SPEAKING CONTACT:

NAME: _____ PHONE: _____

IF THERE IS A CUSTODY AGREEMENT, PLEASE GIVE DETAILS AND ATTACH COPY:

_____

_____

HAS THE CHILD PREVIOUSLY ATTENDED DAYCARE/PRESCHOOL?

YES _____ NO _____ IF **YES**, WHERE? _____

COMMENTS/INSTRUCTIONS TO HELP US CARE FOR YOUR CHILD:

TOILETTING/DIAPERING: _____
REST TIME: _____
EATING/MEALTIME: _____
FEARS: _____

HEALTH INFORMATION: CARECARD PERSONAL HEALTH NO.: _____

DATE EFFECTIVE: _____/_____/_____
YY MM DD

FAMILY DOCTOR: _____ PHONE: _____

FAMILY DENTIST: _____ PHONE: _____

OTHER HEALTH PROFESSIONALS INVOLVED WITH YOUR CHILD:

_____ PHONE: _____

_____ PHONE: _____

_____ PHONE: _____

IF APPROPRIATE, COMMENT ON THE FOLLOWING HEALTH ISSUES:

1. SPECIAL MEDICATIONS: _____
2. SPEECH OR LANGUAGE: _____
3. VISION OR HEARING: _____
4. ALLERGIES OR ASTHMA: _____
   a) Does the child and/or family(i.e. parents and siblings) have a history of allergy or asthma? _____
   b) Has the child had a number of surgeries? _____
   If the answer to either 4.a) or b) is **YES**, fill out a **CHILD ALLERGY / ASTHMA INFORMATION FORM**
5. OTHER (SPECIFY): _____

PARENT'S COMMENTS (IF ANY): _____

_____

_____

_____

_____

This health information is to be made available to the staff of the Vancouver/Richmond Health Board.

I hereby give my consent for my child to be involved in drop-in visits by the Vancouver / Richmond Health Board staff.

SIGNATURE OF THE PERSON PROVIDING THE INFORMATION: _____

SIGNATURE OF THE PERSON RECEIVING THE INFORMATION: _____

DATE: _____/_____/_____
YY MM DD