Write Choice

EARLY LEARNING CENTRE

REGISTRATION FORM

PERSONAL INFORMATION

FULL NAME OF CHILD	USUAL NAME OF CHILD (IF DIFFERENT)		
CHILD'S DATE OF BIRTH (D/M/Y)	GENDER		PREFERRED START DATE
ADDRESS			HOME PHONE
CITY	PROVINCE	POSTAL CODE	PHONE
PARENT OR GUARDIAN:	PARENT OR GUARDIAN:		
ADDRESS (IF DIFFERENT ABOVE)	ADDRESS (IF DIFFERENT ABOVE)		
PHONE	PHONE		
MOBILE	MOBILE		

HEALTH INFORMATION

CARE CARD NUMBER

FAMILY DOCTOR /CLINIC NAME	FAMILY DENTIST / CLINIC NAME
ADDRESS	ADDRESS
PHONE	PHONE

CONSENT FOR EMERGENCY CARE

I AUTHORIZE THE STAFF AT WRITE CHOICE EARLY LEARNING CENTRE TO CALL A MEDICAL PRACTITIONER OR AMBULANCE IN THE CASE OF AN ACCIDENT OR ILLNESS OF MY CHILD(REN), IF THE PARENT/GUARDIAN CANNOT IMMEDIATELY BE REACHED.

SIGNATURE OF PARENT/GUARDIAN

DATE	MANAGER OF FACILITY

Write Choice

EARLY LEARNING CENTRE

REGISTRATION FORM 2

PERSON(S) AUTHORIZED TO PICK UP CHILD (OTHER THAN PARENT/GUARDIAN LISTED ON PG 1)

NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE

PERSON(S) NOT AUTHORIZED TO PICK UP CHILD

NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE

ALTERNATE PERSON(S) TO CALL & PICK UP CHILD IN CASE OF EMERGENCY

NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE
NAME	RELATIONSHIP	PHONE

IS YOUR CHILD UP TO DATE ON IMMUNIZATIONS? (CIRCLE ANSWER) YES NO NOT IMMUNIZED
(ATTACH IMMUNIZATION RECORD IF AVAILABLE)

DIPHTHERIA	PERTUSISS	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		

HEALTH INFORMATION (PLEASE ATTACH A SEPARATE SHEET, IF NECESSARY)

REGULAR MEDICATION(S) AND REASON FOR USE (PLEASE LIST):

ALLERGIES AND TREATMENT TO USE (PLEASE LIST):

COMMENTS

Write Choice

EARLY LEARNING CENTRE

REGISTRATION FORM 3

INJURY(S), ILLNESS(ES) OR OPERATION(S) YOUR CHILD HAS HAD AND INCLUDE DATE(S):

A) PLEASE DESCRIBE ANY CONCERNS/ ISSUES REGARDING YOUR CHILD'S HEALTH (SEIZURES, ASTHMA, VISION, HEARING, ETC)

B) PLEASE DESCRIBE ANY CONCERNS YOU MAY HAVE REGARDING YOUR CHILD'S DEVELOPMENT (I.E. BEHAVIOUR, VISION, HEARING, SPEECH, LANGUAGE, MOBILITY, ETC)

C) DESCRIBE ANY SPECIFIC CARE INSTRUCTIONS A) AND /OR B)

OTHER HEALTH CARE PROFESSIONALS INVOLVED IN YOUR CHILD'S LIFE (I.E. OCCUPATIONAL THERAPIST, PHYSICAL THERAPIST)

GROUP EXPERIENCES

A) WHAT IS/ARE YOUR CHILD'S FAVOURITE TOY(S)/ACTIVITIES:

B) HAS YOUR CHILD HAD PREVIOUS PLAY GROUP EXPERIENCE? (CIRCLE ANSWER) YES NO

C) IF YES, HOW DID HE/SHE ADAPT?

D) HOW DOES YOUR CHILD BEHAVE TOWARD OTHER CHILDREN (I.E. SEEKS OTHERS OUT, FEELS SHY)

EMOTIONAL

A) HOW DOES YOUR CHILD REACT WHEN LEFT WITH UNFAMILIAR PEOPLE AND/OR UNFAMILIAR SITUATIONS?

B) DOES YOUR CHILD HAVE ANY PARTICULAR FEARS? PLEASE DESCRIBE

C) WHAT SUGGESTIONS DO YOU HAVE THAT WOULD HELP STAFF MAKE YOUR CHILD'S TRANSITION INTO THIS PROGRAM EASIER?

Write Choice

EARLY LEARNING CENTRE

REGISTRATION FORM 4

FAMILY AND GENERAL HOUSEHOLD INFORMATION

PLEASE LIST THE NAMES OF THE SIGNIFICANT PEOPLE IN YOUR CHILD'S LIFE (I.E. SIBLINGS, GRANDPARENTS, ETC)

PLEASE DESCRIBE THE GUIDANCE AND DISCIPLINE METHODS USED AT HOME

PRIMARY LANGUAGE SPOKEN IN THE HOME	OTHER LANGUAGES
NAME OF ENGLISH SPEAKING PERSON (IF NEEDED)	PHONE

ANY OTHER COMMENTS

PROGRAM ENROLLMENT

☐ FULL - TIME

☐ PART - TIME

IF PART TIME, CIRCLE DAYS

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

SIGNATURE OF PARENT OR GUARDIAN PROVIDING INFORMATION

SIGNATURE	PRINT NAME	DATE

NOTE: THIS INFORMATION MAY BE REVIEWED BY FRASER HEALTH AUTHORITY LICENSING STAFF AS PER LEGISLATION

FACILITY USE ONLY

STAFF PERSON REVIEWING FAMILY DOCUMENTS

SIGNATURE	PRINT NAME	DATE
CHILD'S START DATE	CHILD'S WITHDRAWAL DATE	REASON FOR WITHDRAWAL