CHILDCARE FACILITIES REGISTRATION FORM (2017-2018)

475 Alexander St. Vancouver, BC V6A 1C6 T: 604-254-2551 F: 604-254-9556 e-mail: vjls@vjls-jh.com www.vjls-jh.com

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

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

SEX: M_____F_____

NAME OF CHILD:_____
(Surname) (Given Name) (名前)

Name the Child responds to: _____

Address: _____ City: _____ Postal: _____

Person(s) with whom the child lives [Adults and Children]:_____

Child's first language: _____ Other languages: _____

Child's Class (es): Required 4 weeks advanced written notice for absence (over 4 consecutive weeks) & withdrawal - excluding Scheduled Break (Winter/Spring/Summer Break) ☐ initial

☐Toddler (2 yrs) : ☐ Tue & Thu **(3 hours)** ☐ Wed & Fri **(3 hours)**

☐Preschool (3 yrs) : ☐ Mon, Wed, Fri **(4 hours)**
☐ Tue & Thu **(4 hours)**
☐ Sat **(3 hours)**

☐Preschool (4 yrs) : ☐ Mon, Wed, Fri **(4 hours)**
☐ Tue & Thu **(4 hours)**
☐ Sat **(3 hours)**

☐Daycare (3 – 5 yrs) : ☐ 3days (Mon, Tue, Wed, Thu, Fri)
☐ 5days

photo

Parent(s)/guardian(s):

1. Name: _____ 名前：_____Home phone: _____

Cellular phone: _____ E-mail:_____

2. Name: _____ 名前：_____Home phone: _____

Cellular phone: _____ E-mail:_____

Person(s) authorized to pick up the child and be contacted in case of emergency (include mother/father/guardian)

1. Name: _____ Relationship to child: _____

Home phone: _____ Cellular phone: _____

2. Name: _____ Relationship to child: _____

Home phone: _____ Cellular phone: _____

3. Name: _____ Relationship to child: _____

Home phone: _____ Cellular phone: _____

If appropriate, list 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

Toileting/Diapering_____

Rest Time_____

Eating/Mealtime_____

Fears_____

HEALTH INFORMATION

Care Card Personal Health No.: _____

Family Doctor:_____ Phone: _____

Family Dentist: _____ Phone: _____

Other health professionals involved with your child:

_____ 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 VJLS/Children's World（こどものくに).

I hereby give my consent for my child to be involved in drop-in visits by Vancouver Coastal Health staff.

Information Provided By: _____ _____

Print Name Signature

Information Received BY: _____ _____

Print Name Signature

DATE: _____/_____/_____

YY MM DD