



**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)

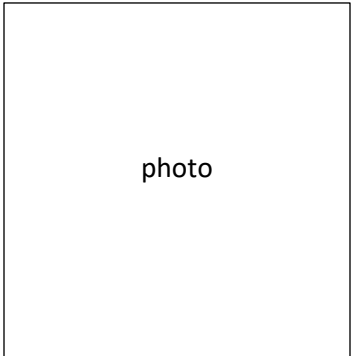
initial

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



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