

# OUR SAVIOUR CHILD CARE CENTRE

6340 No. 4 Road, Richmond, B.C. V6Y 2S9

Tel: (604) 270-6022 e-mail: childcare@oursaviour.ca

## REGISTRATION FORM

**NAME OF CHILD:** \_\_\_\_\_

Surname

Given Name

Middle Name

Name Child responds to: \_\_\_\_\_

Sex: M \_\_\_ F \_\_\_

Child's starting date: \_\_\_\_\_  
year/month/date

Birthdate: \_\_\_\_\_  
year/month/date

Address: \_\_\_\_\_

Postal Code: V \_\_\_\_\_

Phone: \_\_\_\_\_

Child's First Language: \_\_\_\_\_

Child's Second Language: \_\_\_\_\_

Person(s) with whom the child lives: \_\_\_\_\_

### PARENT/GUARDIAN:

Female: Name: \_\_\_\_\_

(Mother) Address: \_\_\_\_\_

Place of Work: \_\_\_\_\_

Hours: \_\_\_\_\_

Phone: (home) \_\_\_\_\_

(work) \_\_\_\_\_

Male: Name: \_\_\_\_\_

(Father) Address: \_\_\_\_\_

Place of Work: \_\_\_\_\_

Hours: \_\_\_\_\_

Phone: (home) \_\_\_\_\_

(work) \_\_\_\_\_

### ALTERNATIVE PERSON(S) TO CALL IN CASE OF EMERGENCY:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ Speaks English? \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_ Speaks English? \_\_\_\_\_

### PERSON(S) AUTHORIZED TO PICK UP CHILD (include mother and father):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

If there is a custody agreement, please give any details you wish us to be aware of: \_\_\_\_\_

\_\_\_\_\_

**SOCIAL INFORMATION:**

Names and birthdates of other children living at home: \_\_\_\_\_

Has child previously attended day care/pre-school? Yes \_\_\_ No \_\_\_

Name of facility: \_\_\_\_\_

**HEALTH/NUTRITION INFORMATION:**

Words child uses for toileting: \_\_\_\_\_

Illness(es) child has had: \_\_\_\_\_

Does the child: (circle appropriate answer)

Have vision problems? YES/NO      Have hearing problems? YES/NO

Have speech/language problems? YES/NO      Have allergies? YES/NO

Take medications? YES/NO      Have food dislikes? YES/NO

Require special diet? YES/NO      Have other health concerns? YES/NO

Please specify and comment on any other item(s) marked "YES"

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMMUNIZATION RECORD:** - Attach photocopy of immunization record, or indicate dates that immunization was received.

Diphtheria, Tetanus and Pertussis (DPT): \_\_\_\_\_ Polio: \_\_\_\_\_

Meningitis (Hib D): \_\_\_\_\_ Measles, Mumps, and Rubella (MMR): \_\_\_\_\_

**EMERGENCY HEALTH INFORMATION:**

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_ Address: \_\_\_\_\_

Care Card No.: \_\_\_\_\_

**ADDITIONAL COMMENTS (IF ANY):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Date