Name of Facility:

CHILD'S STARTING DATE: **SEX:** **DATE OF BIRTH:**

_____/ _____/ _____ **M ____ F ____** **_____/ _____/ _____**
YY MM DD **YY MM DD**

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: _____ Cell phone: _____

Work phone: _____ Days/hours of work: _____ E-mail: _____

Name: _____ Home phone: _____ Cell phone: _____

Work phone: _____ Days/hours of work: _____ E-mail: _____

Person(s) authorized to pick up the child and be contacted in case of emergency. These people should be available during hours of care. (include mother / father / guardian):

Name: _____ Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Name: _____ Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Name: _____ Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Name: _____ Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

If appropriate, list an English speaking contact:

Name: _____ Phone: _____

Has the child previously attended daycare/preschool?

YES ☐ NO ☐ Comments: _____

Comments/instructions to help us care for your child. (Please feel free to add additional pages.):

Toileting/Diapering (special words): _____

Rest Time (special comfort – toy/blanket): _____

Eating/Mealtime (include food likes/dislikes): _____

Fears: _____

Please tell us anything else you think will help us provide an enriching experience for your child: _____

_____

_____

HEALTH INFORMATION

Health professionals involved with your child (other than doctor and dentist):

NAME	PROFESSION/AGENCY	
_____	_____	Phone: _____
_____	_____	Phone: _____
_____	_____	Phone: _____

Does your child have:

A medical condition/concern? YES ☐ NO ☐
If yes, please provide further information: _____

Allergies? YES ☐ NO ☐
If yes, please provide further information: _____

Asthma? YES ☐ NO ☐
If yes, please provide further information: _____

Has your child had a seizure in the past year? YES ☐ NO ☐
If yes, please provide further information: _____

Does your child require a special diet related to a medical condition? YES ☐ NO ☐
If yes, please provide further information: _____

Food sensitivities? YES ☐ NO ☐
If yes, please provide further information: _____

List all prescription and "over the counter" medications your child receives:

Medication	Times Given	Reason for Medication
_____	_____	_____
_____	_____	_____

You may be asked to complete additional forms if you answered yes to any of the above.

This health information may be made available to the staff of Vancouver Coastal Health.

Custody Agreement YES ☐ N/A ☐ **Provided to Facility** YES ☐ NO ☐ N/A ☐
Immunization Documents Returned to Facility YES ☐ NO ☐

Information Provided By: _____ _____
Print Name Signature

DATE: _____/_____/_____
YY MM DD

Information Received By: _____ _____
Print Name Signature

DATE: _____/_____/_____
YY MM DD

Office Use Only

Date Child Leaves the Facility: DATE: _____/_____/_____
YY MM DD