Enrollment for Prescott and Russell Licensed Home Child Care Agency

Child

Name:_____ Gender:_____

Date of birth (d/m/y): _____

Parent-1

Name: _____ Date of birth (d/m/y): _____

Home address: _____

City:_____Postal Code: _____

Cell #:_____Other #: _____

Email address: _____

Work address: _____

Telephone #: _____

Parent-2

Name:_____ Date of birth (d/m/y): _____

❒ Same address as Parent-1

Home address: _____

City:_____Postal Code: _____

Cell #:_____Other #: _____

Email address: _____

Work address: _____

Telephone #: _____

Child lives with:

❒ Both parents ❒ Mother only

❒ Father only ❒ Other: _____

Care preferred in which language?

❒ French ❒ English

Attendance

Date of care needed: _____

❒ Day ❒ Half day

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
❒ AM	❒ AM	❒ AM	❒ AM	❒ AM	❒ AM	❒ AM
❒ PM	❒ PM	❒ PM	❒ PM	❒ PM	❒ PM	❒ PM

Drop-off time:_____Pick-up time: _____

Preferred Areas:

_____

_____

In Case of Emergency

Name of person to be contacted if parents cannot be reached in case of an emergency during the hours of care:

_____Telephone #: _____

Persons, other than parents, to whom the child may be released:

1._____2. _____

3._____4. _____

Medical Information

Child's family physician:_____

Address:_____City:_____

Telephone #: _____

All children enrolled in authorized Child Care programs must be immunized as recommended by the local medical officer of health, unless otherwise exempted.

Please attach a copy of your child's immunization record.

1. **Special medical conditions**: ☐ Yes ☐ No

   If you checked yes, please specify;

   _____

   _____

2. **Child's allergies**: ☐ Yes ☐ No

   If you checked yes, please specify; _____

   For each child with an anaphylactic allergy, with your participation, the development of an individual plan that includes emergency procedures applicable to the child must be filled out.

3. **Food intolerance**:☐ Yes ☐ No

   If you checked yes, please specify; _____

4. **Symptoms of child's ill health** *(indicate child's usual reaction to illness; e.g., high temperature, flushing, vomiting, irritability…).*

   _____

   _____

5. **Medical treatment, drug or medication to be administered during child care hours**: ☐ Yes ☐ No

   Written and signed instructions must be provided by a parent of the child

   If you checked yes, please specify : _____

Additional information

Please share with us some additional information about your child
(e.g., child's habits, toilet routine, favourite activities, routines, fears, etc.)

_____

_____

_____

Parent's signature: _____ Date: _____

For office use

Date of admission: _____ Date of discharge: _____

Prescott and Russell Early Years Services
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