



<b>Child's Name:</b>	<b>Parent's Name:</b>
<b>School:</b>	<b>Contact:</b>

**Please Check if you are eligible for subsidy**

Please select the week(s) below you would like to register for. Please note priority will be given to children registering for full week care and those currently enrolled in out of school care, with remaining spaces given to children registering daily.

<b>Rate of Care Full Week: \$200</b>	<b>Rate of Care Daily: \$50</b>
--------------------------------------	---------------------------------

Please note the price of fill time in a week with stat holiday occurring is \$180

<b>Full Week</b>	<b>Daily Rate</b>	<b>Week: Date (Theme)</b>	<b>If Daily Rate selected please specify dates care is required below</b>
		Week 1: July 4 - July 8 (Around the World in 5 Days)	
		Week 2: July 11 - July 15 (Playground Hopping)	
		Week 3: July 18 - Jul 22 (Board Game Bonanza)	
		Week 4: July 25 - July 29 (Nature Seekers)	
		Week 5: August 2 - August 5 (Secome a Scientist)	
		Week 6: August 8 - August 12 (To the Beach!)	
		Week 7: Aug 15 - August 19 (PHC Foodies)	
		Week 8: August 22 - August 26 (Movin' and Groovin')	
		Week 9: August 29 - September 2 (Camp Classics)	

By signing below documents, I consent that all information within this registration package is correct and I have read and understand all policies and procedures of Pacificheart Childcare Inc. I am responsible for the full cost of care. Please see sign all provided documents and return to [pacificheartchildcare@gmail.com](mailto:pacificheartchildcare@gmail.com)



# CHILD CARE REGISTRATION FORM

(Include a photo of child)



## FACILITY

Name of Facility:

Date of Enrollment:

## CHILD

Name of Child:

SURNAME

GIVEN

MIDDLE NAME

Name Child Responds To:

Gender:

Address:

Date of Birth:

First Day of Attendance:

End Date:

## PARENT/GUARDIAN

Name:

Place of Work:

Phone:

Local:

Home Address:

Phone:

Hours of Work:

Postal Code:

E-mail Address:

Name:

Place of Work:

Phone:

Local:

Home Address:

Phone:

Hours of Work:

Postal Code:

E-mail Address:

## MEDICAL INFORMATION

Family Doctor:

Phone:

Medical Insurance Plan Number:

Date Effective:

## ALTERNATE PERSON TO CALL/PICK-UP CHILD IN CASE OF EMERGENCY

Name:

Relationship:

Phone:

Name:

Relationship:

Phone:

## PERSONS (OTHER THAN PARENT/GUARDIAN AND EMERGENCY CONTACTS) AUTHORIZED TO PICK UP CHILD FROM FACILITY

Name:

Phone:

Name:

Phone:

## PERSONS NOT PERMITTED ACCESS TO CHILD

Name:

Phone:

Name:

Phone:

Are there custody orders?

Yes

No

If Yes, Attach documentation

## NAMES OF OTHER CHILDREN LIVING AT HOME

Name:

Date of Birth:

Name:

Date of Birth:

Has child had previous experience away from home? (Day Care, Preschool, Sunday School, etc.)

Yes

No

If Yes, Explain:

Where?

Date of Attendance:

Do you think your child feels comfortable leaving parents?

Yes

No

Explain:

Does this child have any known health problems/medical disabilities? Yes No

If Yes, Attach documentation

List any communicable diseases child has had:

Has he/she had any recent illness? Yes No

If Yes, Explain:

Any allergies? Yes No If Yes, Please List:

**IF YES, ATTACH SPECIAL INSTRUCTIONS TO FOLLOW IN THE EVENT OF AN ALLERGIC REACTIONS**

What is the child's eating habit?

Favourite Foods:

Strong Dislikes:

**BASIC SCHEDULE AND RECORD OF IMMUNIZATION AS SUBMITTED BY PARENT/GUARDIAN**

(Attach Immunization Record - or Record the dates)

First Visit - Two months of Age:

- Diphtheria**
- Pertussis**
- Tetanus**
- Polio**
- Haemophilus Influenza Type B (hib)**
- Hepatitis B**
- Pneumococcal Conjugate**
- Meningococcal C Conjugate**

Second Visit - Two months after first visit:

- Diphtheria**
- Pertussis**
- Tetanus**
- Polio**
- Haemophilus Influenza Type B (hib)**
- Hepatitis B**
- Pneumococcal Conjugate**

Third Visit - two months after second visit:

- Diphtheria**
- Pertussis**
- Tetanus**
- Polio**
- Haemophilus Influenza Type B (hib)**
- Hepatitis B**
- Pneumococcal Conjugate**

Fourth Visit - 12 months of age:

- Measles**
- Mumps**
- Rubella**
- Meningococcal C Conjugate**
- Varicella (Chicken Pox)**

Fifth Visit - 12 months after third visit:

- Diphtheria**
- Pertussis**
- Tetanus**
- Polio**
- Haemophilus Influenza Type B (hib)**
- Measles, Mumps, Rubella**
- Pneumococcal Conjugate**

4 to 6 years of age:

- Diphtheria**
- Pertussis**
- Tetanus**
- Polio**
- Varicella (Chicken Pox)**

Other Immunizations:

**BY MY SIGNATURE BELOW I ACKNOWLEDGE THE FOLLOWING:**

I hereby give my consent for a staff member to call a medical practitioner or ambulance for my child in the case of accident or illness, If I cannot immediately be reached.

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
CAREGIVER SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DATE

