Discovery Preschool

Discovery Preschool Registration Form

❑ Beckenridge ❑ Heritage ❑ On 7 ❑ Unionville

CHILD INFORMATION:

Last Name:	First Name:		Date of Birth (YY/MM/DD):	
Telephone:	Sex: ☐ M ☐ F	Starting Date:	Withdrawal Date:	Does child live with: Mother ☐ Father ☐ Both ☐

Food Restrictions:

ALLERGIES:

Does your child have allergies? Yes ☐ No ☐

If yes, please indicate below:

Allergy	Mild-Moderate	Severe	Life Threatening

If your child has food restrictions or allergies, you will be required to complete *Allergy Screening* and/or *Anaphylactic Alert Notice* form prior to start date (please ask supervisor for copy).

Please indicate if you have completed *Allergy Screening:* Yes ☐ No ☐

Please indicate if you have completed *Anaphylactic Alert Notice:* Yes ☐ No ☐

Health Concerns: Has your child had any communicable diseases? Yes ☐ No ☐

If Yes, please provide details: _____

_____

Has your child been under the guidance of Earlv Intervention or any other agency related to development, medical or behaviour needs? - (see inclusion policy) Yes ☐ No ☐

If Yes, please provide details: _____

_____

PARENT/GUARDIAN CONTACTS:

Mother ☐ Father ☐ Guardian ☐			Mother ☐ Father ☐ Guardian ☐		
Last Name:	First Name:		Last Name:	First Name:	
Home Address:			Home Address:		
City:	Province:	Postal Code:	City:	Province:	Postal Code:
Home Telephone:			Home Telephone:		
Daytime Location (employer, school, home, etc):			Daytime Location (employer, school, home, etc):		
Daytime Address:			Daytime Address:		
Daytime Telephone:			Daytime Telephone:		
Cellular Telephone:			Cellular Telephone:		
Email Address:			Email Address:		

Parent/Guardian Initials	Supervisor Initials:

Empowering Childhood Experiences

Discovery Preschool

Discovery Preschool Registration Form

PERSONS AUTHORIZED TO PICK UP CHILD:

I/We authorize ONLY the following persons to pick up my child from the Program (all of whom are over 18 years of age) or act as an emergency contact in the event that I/We cannot be reached: Under no circumstance will your child be released to anyone not listed below without written authorization:

	Persons Name	Relationship	Address:	Daytime Telephone:	Cellular:
1					
2					
3					

Custody Agreement Details (if any):

MEDICAL INFORMATION:

Family Doctor:	Phone Number:	
Doctor's Full Address:	City, Province:	Postal Code:

Is your child Immunized?: Yes ☐ If Yes, proof of child's record of immunization has been provided? Yes ☐ No ☐

No ☐ If No, notice of exemption has been provided? Yes ☐ No ☐

Call the York Region Community and Health Services Immunization Team at 1-877-794-1880 if your child has not been immunized, or if an exemption is requried.

Previous Medical History - please indicate all that apply:

	German Measles		Poliomyelitis		Measles		Tuberculosis
	Chicken Pox		Small Pox		Asthma		Giardia Lamblia
	Rheumatic Fever		Eczema		Mumps		Diphtheria
	Scarlet Fever		Reaction to bites		Reaction to stings		Whooping Cough

PARENT/GUARDIAN PERMISSIONS:

I hereby consent to the collection, use and disclosure of my child's information by the centre for the purpose of providing child care services to my child enrolled in Centre programs. I understand that the Centre protects the privacy of all personal information in its possession in compliance with prevailing privacy legislation**. I acknowledge that enrolment is contingent on all information outlined in these forms being full and accurate.**

Parent/Guardian (Please Print):	Parent/Guardian Signature:	Date:
Supervisor (Please Print):	Supervisor Signature:	Date: