

FACILITY NAME Bright Futures Specialized Childcare	
FULL NAME OF CHILD	USUAL NAME OF CHILD <i>(if different)</i>

PERSONAL INFORMATION		(Facility opens Mon., Sep. 13/21)
CHILD'S DATE OF BIRTH	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	STARTING DATE
ADDRESS		FACILITY USE ONLY WITHDRAWAL DATE
POSTAL CODE	TELEPHONE ()	
PARENT OR GUARDIAN		PARENT OR GUARDIAN
ADDRESS <i>(if different from above)</i>		ADDRESS <i>(if different from above)</i>
TELEPHONE ()		TELEPHONE ()
WORK ADDRESS / ALTERNATE LOCATION		WORK ADDRESS / ALTERNATE LOCATION
TELEPHONE <i>(Include Local / Extension)</i> ()		TELEPHONE <i>(Include Local / Extension)</i> ()
CELL PHONE / PAGER ()		CELL PHONE / PAGER ()
HOURS AT THIS LOCATION		HOURS AT THIS LOCATION

EMERGENCY HEALTH INFORMATION	
CARE CARD NUMBER	
FAMILY DOCTOR / CLINIC NAME	DOCTOR / CLINIC TELEPHONE ()

CONSENT FOR EMERGENCY CARE	
I authorize the staff at the child care centre to call a medical practitioner or ambulance / transport child to emergency medical care, in the case of accident or illness of my child(ren), if the parent cannot immediately be reached.	Yes <input type="checkbox"/> No <input type="checkbox"/>

ALTERNATE PERSONS(S) AUTHORIZED TO PICK UP CHILD <i>(other than parent/guardian listed above, include emergency pickup)</i>				
<i>Check all that apply</i>				
Name	Relationship	Telephone	Authorized to Pickup	Authorized to Call in an Emergency
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

PERSONS(S) WHO ARE NOT PERMITTED ACCESS TO MY CHILD		
Name	Relationship	Telephone

CUSTODY OR OTHER LEGAL ORDERS		
Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, supply a copy of the order to the facility Manager / Licensee

CHILD'S IMMUNIZATION STATUS			
Is your child up to date on immunizations?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not Immunized <input type="checkbox"/>
COMMENTS			

HEALTH INFORMATION <i>(attach a separate sheet, if necessary)</i>
REGULAR MEDICATION(S) AND REASONS FOR <i>(please list)</i>
ALLERGIES AND TREATMENT OF <i>(please list)</i>
INJURY(S), ILLNESS(ES) OR OPERATIONS YOUR CHILD HAS HAD AND INCLUDE DATE(S) 1. Please describe any concern(s) / issues regarding your child's health (seizures, asthma, vision, hearing, etc). 2. Please describe any concerns you may have regarding your child's development (i.e. behaviour, vision, hearing, speech, language, mobility, etc.) 3. Describe any specific care instruction regarding 1) and/or 2) above.
OTHER HEALTH CARE PROFESSIONALS INVOLVED IN YOUR CHILD'S LIFE <i>(e.g. occupational therapist / physical therapist)</i>

ANY OTHER INFORMATION I SHOULD KNOW
Please include email addresses for all parents/guardians in this section.

SIGNATURE OF PARENT OR GUARDIAN PROVIDING INFORMATION		
SIGNATURE	PRINT NAME	DATE

NOTE: This information may be reviewed by Fraser Health Authority Licensing staff as per legislation.

FACILITY USE ONLY *(Facility has provided a copy of the following)*

1. Prepayment policy Yes No

2. Behavioural Guidance Yes No

ADDITIONAL INFORMATION ABOUT YOUR CHILD (OPTIONAL)

GROUP EXPERIENCES		
WHAT IS/ARE YOUR CHILD'S FAVOURITE TOY(S) / ACTIVITIES		
HAS YOUR CHILD HAD PREVIOUS PLAY GROUP EXPERIENCE? Yes <input type="checkbox"/> No <input type="checkbox"/> IF YES, HOW DID HE/SHE ADAPT?		
HOW DOES YOUR CHILD BEHAVE TOWARD OTHER CHILDREN? (E.G. SEEKS OTHERS OUT, FEELS SHY)		
EMOTIONAL		
HOW DOES YOUR CHILD REACT WHEN LEFT WITH UNFAMILIAR PEOPLE AND/OR IN UNFAMILIAR SITUATIONS?		
DOES YOUR CHILD HAVE ANY PARTICULAR FEARS? PLEASE DESCRIBE.		
WHAT SUGGESTIONS DO YOU HAVE THAT WOULD HELP STAFF MAKE YOUR CHILD'S TRANSITION INTO THIS PROGRAM EASIER?		
FAMILY AND GENERAL HOUSEHOLD INFORMATION		
PLEASE LIST THE NAMES OF THE SIGNIFICANT PEOPLE IN YOUR CHILD'S LIFE (E.G. SIBLINGS, GRANDPARENTS, ETC)		
PLEASE DESCRIBE THE GUIDANCE AND DISCIPLINE METHODS USED AT HOME.		
PRIMARY LANGUAGE SPOKEN IN THE HOME	OTHER LANGUAGES	
NAME OF ENGLISH SPEAKING PERSON (IFF NEEDED)	TELEPHONE	
EATING AND NUTRITION		
LIST YOUR CHILD'S FAVOURITE FOOD		
LIST ANY DISLIKED FOOD.		
PLEASE DESCRIBE ANY PARTICULAR EATING PATTERNS.		
ARE THERE ANY RELIGIOUS OR ETHNIC OBSERVANCES RELATED TO FOODS?		
SLEEPING		
NAP TIME	HOW LONG TO SETTLE	TIME OF WAKING
BEDTIME	HOW LONG TO SETTLE	TIME OF WAKING
DOES YOUR CHILD TAKE A FAVOURITE COMFORTER (E.G. BLANKET OR TOY) TO BED? Yes <input type="checkbox"/> No <input type="checkbox"/> IF YES, DESCRIBE AND TELL US IF IT IS "NAMED".		
WHAT IS YOUR CHILD'S MOOD UPON WAKENING?		
TOILETING		
IS YOUR CHILD TOILET TRAINED? Yes <input type="checkbox"/> No <input type="checkbox"/> PARTIALLY <input type="checkbox"/>		
PLEASE INDICATE YOUR CHILD'S FREQUENCY OR PATTERNS FOR BOWEL MOVEMENTS.		
DESCRIBE ASSISTANCE NEEDED FOR TOILETING.		
WHAT "SPECIAL" WORD DOES YOUR CHILD USE FOR?	URINATION:	BOWEL MOVEMENTS:
_____	_____	_____