2663 West King Edward Vancouver, BC V6L 1T5, Tel: 604 568 8059, Email: info@creativekidsmontessori.com

REGISTRATION FORM

CHILD'S STARTING DATE:	DATE OF BIRTH:	SEX:
_____/ _____/ _____/	_____/ _____/ _____/	M ❑ F ❑
YEAR MONTH DATE	YEAR MONTH DATE	

NAME OF CHILD: _____
(SURNAME, GIVEN NAME, ALSO KNOWN AS)

NAME CHILD RESPONDS TO: _____

ADDRESS: _____ **POSTAL CODE:** _____

PHONE: _____

PERSON(S) WITH WHOM CHILD LIVES (ADULTS & CHILDREN):

CHILD'S FIRST LANGUAGE: _____ SECOND LANGUAGE: _____

PARENT(S)/GUARDIAN(S):

NAME: _____ HOME PHONE: _____
WORK PHONE: _____ LOCAL: _____ DAY/HOURS OF WORK: _____
EMAIL:

NAME: _____ HOME PHONE: _____
WORK PHONE: _____ LOCAL: _____ DAY/HOURS OF WORK: _____
EMAIL: _____

PERSON(S) AUTHORIZED TO PICK UP CHILD AND/OR BE CONTACTED IN CASE OF EMERGENCY (INCLUDE: MOTHER / FATHER / GUARDIAN):

NAME: _____ RELATIONSHIP TO CHILD: _____
HOME PHONE: _____ WORK PHONE: _____

NAME: _____ RELATIONSHIP TO CHILD: _____
HOME PHONE: _____ WORK PHONE: _____

NAME: _____ RELATIONSHIP TO CHILD: _____
HOME PHONE: _____ WORK PHONE: _____

NAME: _____ RELATIONSHIP TO CHILD: _____
HOME PHONE: _____ WORK PHONE: _____

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IF APPROPRIATE, ENGLISH SPEAKING CONTACT:

NAME: _____ PHONE: _____

IF THERE IS A CUSTODY AGREEMENT, PLEASE GIVE DETAILS AND ATTACH COPY:

_____

_____

_____

HAS CHILD PREVIOUSLY ATTENDED DAYCARE / PRESCHOOL?

YES: ❑ NO: ❑ IF YES, WHERE? _____

COMMENTS / INSTRUCTIONS TO HELP US CARE FOR YOUR CHILD:

TOILETING/DIAPERING: _____

REST TIME: _____

EATING/MEALTIME: _____

FEARS: _____

HEALTH INFORMATION

FAMILY DOCTOR: _____ PHONE: _____

FAMILY DENTIST: _____ PHONE: _____

OTHER HEALTH PROFESSIONALS INVOLVED WITH YOUR CHILD:

_____ PHONE: _____

_____ PHONE: _____

_____ PHONE: _____

PERSONAL HEALTH NUMBER: **DATE EFFECTIVE:**

_____ _____/_____/_____/

YEAR MONTH DATE

IF APPROPRIATE, COMMENT ON THE FOLLOWING HEALTH ISSUES:

SPECIAL MEDICATIONS: _____

VISION OR HEARING: _____

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REGISTRATION FORM

ALLERGIES: _____

SPEECH OR LANGUAGE: _____

OTHER: _____

PARENTS' COMMENTS (IF ANY):

_____

_____

_____

_____

_____

_____

_____

_____

This health information is to be made available to the staff of the ***Vancouver Health Department.***

I give my consent for my child to be involved in drop-in visits by the Vancouver Health Department staff.

SIGNATURE OF PERSON PROVIDING INFORMATION: _____

SIGNATURE OF PERSON RECEIVING INFORMATION: _____

DATE: _____/ _____/ _____/
YEAR MONTH DATE