

Child Information *Has your child/children attended a VWCA childcare program before?* Yes No

Program Applied For: Preschool: Daycare: Before School Care: After School Care:

First Name: Last Name: Gender:

Address: Postal Code: City:

Date of Birth: Age: Preferred Pronoun:

Parent Guardian Information Child's Grade as of September 1st:

Parent Guardian Name: Cell Phone:

Email: Daytime/Work Phone:

Parent Guardian Name: Cell Phone:

Email: Daytime/Work Phone:

Child currently lives with:

Both Parents: Mother: Father: In Care: Shared Custody: Other:

Custody Arrangement: Yes No **If yes, you must attach a Custody/Court Order**

Emergency Contact Information (Two contacts MUST be different than parent/guardian)

Emergency Contact Name: Relationship:

Daytime/Work Phone: Cell Phone:

Emergency Contact Name: Relationship:

Daytime/Work Phone: Cell Phone:

Health & Special Considerations BC Service Card Number (Care Card):

Physician Name: Physician Phone Number:

What special considerations should we be aware of to better meet your child's needs. (Check all boxes that apply)

<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Visual	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	ADHD/ADD	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Speech
<input type="checkbox"/>	Emotional/Psychological	<input type="checkbox"/>	Autism Spectrum Disorder	<input type="checkbox"/>	Medical or Health Conditions/Restrictions						

Please describe all checked considerations and any other considerations your child might have.

Behavioural Concerns

Does your child require a support worker to participate? No Yes

Does your child have any behavioural concerns we should be aware of? No Yes

Please explain these concerns:

How can our staff better meet your child's needs?

Does your child currently receive funding for 1:1 support? No Yes

Please specify funding program/agency:

**** Please Note: A staff member may contact you for further clarification or to set up a care plan. Failure to disclose and health and/or safety considerations may result in withdrawal from the program if the Association is unable to accommodate the needs of your child.****

Immunization Record

My child is up to date on all immunizations. **I have attached ALL immunization records for my child**

I choose not to immunize my child and agree to temporarily withdraw my child from the program should the community be facing an epidemic.

Child Pick Up Information (other than parent/guardian)

I, the parent/guardian or the designate(s) listed below (including emergency contacts listed) will pick up my child at the program completion time.

Signature of Parent: Phone:

Designate(s)

Name: Relationship:

Name: Relationship:

Do Not Release Please list those who under any circumstances are NOT ALLOWED ACCESS (release of child or on-site visit) *** if possible, please provide a recent photo***

Name: Relationship:

Name: Relationship:

Administration of Prescription Medication at a Child Care Facility

N/A:

Name of Child: Date of Birth:

Name of Parent/Guardian: Cell Phone:

Physician: Physician Phone:

TO BE COMPLETED BY PHYSICIAN:

Name of Medication(s):

Condition(s) Which Makes Medication(s) Necessary:

Dosage: Pills Drops Tsp Ounce Mls

Start Date: End Date:

Time: AM PM To Be Given With: *Food, Water, Juice*

Additional Comments *(Possible reactions, consequences of missing medications, etc)*

Physician Name: *(Printed)*

Date:

Signed: _____

Anaphylaxis Emergency Plan

N/A:

Name of Child:

My Child is Allergic To...

Peanut Eggs Insect Stings Latex Medication Tree Nuts Milk

Other (Please Specify):

Epinephrine Auto-Injector Expiry Date:

Dosage: EpiPen Jr 0.15mg EpiPen 0.30mg Twinject 0.15mg Twinject 0.30mg

Location of Auto-Injector:

Asthmatic Person is at greater risk. If person is having a reaction and has difficulty breathing, give epinephrine auto-injector before asthma medication.

Please select/circle all symptoms your child has when experiencing an anaphylactic reaction.

- Skin** Hives, swelling, itching warmth, redness, rash
- Respiratory** Wheezing, shortness of breath, throat tightness, cough, hoarse voice, chest pain/tightness, nasal congestion, trouble swallowing.
- Gastrointestinal** Nausea, pain/cramps, vomiting, diarrhea
- Cardiovascular** Pale/blue colour, weak pulse, passing out, dizzy, shock
- Other** Anxiety, feeling of "impending doom", headache

Emergency Contact Information

Name: Relationship:

Cell Phone: Daytime/Work Phone:

Name: Relationship:

Cell Phone: Daytime/Work Phone:

The undersigned parent, or guardian authorizes any adult to administer epinephrine to the above named person in the event of an anaphylactic reaction, as described above. This protocol has been recommended by the patient's physician.

Parent/Guardian Signature

Date

Physician Signature

Date

Current Photo Must be Recognizable, please attach 2 copies

Attach Photo Here

Attach Photo Here

I give permission for photographs of my child to be used for publicity purposes connected with the Victoria West Community Association.

Yes

No

Parent Initials

In Case of Accident or Illness

In the event that I cannot immediately be reached, I authorize VWCA staff to call a medical practitioner or ambulance in case of accident or illness.

Parent Signature: _____

Date: _____

Is there any other information we should know?

Application Checklist Please ensure all items are completed and attached prior to registration.

- Registration Form - Completed & Signed
- Immunization Records Attached
- Two Recent Photos of your Child
- Government Subsidy Authorization (If Applicable)
- Legal Copy of Custody Restrictions (If Applicable)
- Direct Debit Form**
- \$100 Deposit/Admin Fee Paid, please visit www.cogran.io/index.html?victoriawest#/home**

I verify that the information provided is accurate and up-to-date. Should any changes occur, I will notify the VWCA as soon as possible. I understand that incomplete registration forms will not be processed and space will not be held for my child.

Parent/Guardian Signature: _____ Date: _____

Form Submission & Additional Information

Thank you for completing your registration form. Please return the completed form to our administration office, located at 521 Craigflower Rd in the Victoria West Community Centre. Please ensure all attachments are included and all applicable fields are filled or else your form will not be processed.

Do not hesitate to contact us if you no longer need care, or if you would like to change any of the information on your registration form.

Notification of program acceptance will be provided by June 1st at the latest. WE ARE UNABLE TO ANSWER ANY QUESTIONS REGARDING THE STATUS OF YOUR APPLICATION UNTIL AFTER THAT DATE. We ask that you respect this policy during this busy time.

Note: You will be contacted by mail to confirm your registration.

*******OFFICE USE ONLY*******

Date Received: _____ Confirmation Sent: _____

Staff Verification Signature: _____ Entered in Cogran: _____