VIC WEST COMMUNITY ASSOCIATION

LICENSED GROUP CHILD CARE APPLICATION FORM

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)

☐ Asthma ☐ Visual ☐ Hearing ☐ ADHD/ADD ☐ Seizures ☐ Speech

☐ Emotional/Psychological ☐ Autism Spectrum Disorder ☐ 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.

Name: Relationship:

Name: Relationship:

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Please ensure all fields are completed.

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:

Signature of Parent: _____ Phone: _____

Designate(s)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Please list those who under any circumstances are NOT ALLOWED ACCESS (release of child or on-site visit)

Do Not Release

*** if possible, please provide a recent photo***

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:

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Please ensure all fields are completed.

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, diarrea

☐ **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*

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Please ensure all fields are completed.

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.

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Please ensure all fields are completed.

Application Checklist

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

- ☐ Registration Form - Completed & Signed
- ☐ Regi 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**

☐ Does your child have a sibling at Vic West Elementary School

VIC WEST COMMUNITY ASSOCIATION 521 Craigflower Rd. Victoria, BC - (250)-590-8922 - www.victoriawest.ca

Parent Signature: _____ Date: _____

Is there any other information we should know?

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

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.

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Please ensure all fields are completed.

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

Date Received: _____ Confirmation Sent: _____

Staff Verification Signature: _____ Entered in Cogran: _____

Enrollment Date: