**CHILD INFORMATION:**

|  |  |
| --- | --- |
| Legal Name (as shown on identification – First, Middle, Last): | Name Child Responds to: |
| Date of Birth (dd/mm/yyyy): | Sex: □ M □ F | Language spoken at home: | Requested Starting Date (dd/mm/yyyy):  |
| Street Address: | City, Province: | Postal Code: |
| Student resides with: |

**CONTACT INFORMATION (PARENT(S)/LEGAL GUARDIAN(S)):**

|  |  |  |
| --- | --- | --- |
| **PARENT/LEGAL GUARDIAN #1: (first to contact):** | Email address: | Relationship to student: |
| Address: | Home/Cell Phone Number:  |
| Place of Work: | Work Phone Number:  | Best number to call between 7am – 6am  |
| **PARENT/LEGAL GUARDIAN #1: (second to contact):** | Email address: | Relationship to student: |
| Address: | Home/Cell Phone Number: |
| Place of Work: | Work Phone Number:  | Best number to call between 7am – 6am  |

**CONTACT INFORMATION (EMERGENCY & AUTHORIZED PICK-UP):**

|  |  |  |
| --- | --- | --- |
| **EMEGENCY CONTACT #1: (third to contact):** | Relationship: | Phone Number: |
| Address: | Speak English? □ Yes □ No | If no, what language? |
| **EMEGENCY CONTACT #2: (fourth to contact):** | Relationship: | Phone Number: |
| Address: | Speak English? □ Yes □ No | If no, what language? |
| **AUTHORIZED CONTACT #1: (fifth to contact):** | Relationship: | Phone Number: |
| Address: | Speak English? □ Yes □ No | If no, what language? |
| **AUTHORIZED CONTACT #2: (sixth to contact):** | Relationship: | Phone Number: |
| Address: | Speak English? □ Yes □ No | If no, what language? |

**LIST ANY PERSONS NOT PERMITTED TO ACCESS (PROVIDE COPY OF ANY CUSTODY AGREEMENTS YOU WISH FOR US TO BE AWARE OF:**

**OUT OF PROVINCE CONTACT (IF NONE, PLEASE PROVIDE A CONTACT FROM OUTSIDE THE LOCAL AREA):**

|  |  |  |
| --- | --- | --- |
| Name: | Relationship: | Phone Number: |

**OTHER CHILDREN LIVING AT HOME:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | Date of Birth (dd/mm/yyyy): | Name: | Date of Birth (dd/mm/yyyy): |
| Name: | Date of Birth (dd/mm/yyyy): | Name: | Date of Birth (dd/mm/yyyy): |

**HAS THE CHILD PREVIOUSLY ATTENDED DAYCARE/PRE-SCHOOL?**

|  |  |
| --- | --- |
| □ Yes □ No | Name of Facility: |

**EMERGENCY HEALTH CARE INFORMATION:**

|  |  |
| --- | --- |
| Doctor’s Name: | Phone Number: |
| Dentist’s Name: | Phone Number: |
| Other Name: | Phone Number: |
| Personal Health Number:  |

**EMERGENCY CONSENT AND REGISTRATION AGREEMENT:**

It is the policy of the DOUGLAS PARK JB4 Program to notify a parent/guardian when a child is ill or needs medical attention. Occasionally, we cannot contact the parent/guardian and immediate help is required. Our procedure is to transport the child to the Langley Memorial Hospital.

By checking this box and signing below, I allow the Douglas Park JB4 Staff to act on my behalf for my child in the event of a medical emergency.

I have accurately completed all necessary enrolment forms as required for my child.

I have read the Parent/Guardian Handbook, in particular Sections 2: Enrollment and Section 3: Daily Operation Information. I understand that failure to abide by the outlined policies and procedures may result in my child being removed from the program.

I have provided a current photo of my child.

I have provided a copy of my child’s immunization information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Name (First and Last) Parent/Guardian’s Signature Date:

Just B4 Preschool Parent/Provider Agreement

This agreement is intended to serve as a guideline in the development of a satisfactory preschool arrangement between Douglas Park JB4 Pre-School and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Caregiver)

concerning the care of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 (child’s name)

**Hours of Operation:**

* Tuesdays + Thursdays
* 12:30-2:30pm
* The preschool is open February to June and will follow all Langley School District closures.
* We are also closed all statutory holidays. Preschool fees do not change for closures.

**Fees:**

|  |  |
| --- | --- |
| Program (check one) | Monthly |
|  | Just B4 Preschool (2 days per week)-Tues & Thurs | $120 |

If my child(ren) does not come to preschool for any reason, I understand that I am still responsible for full payment.

I agree to abide by the Health and Sick Policies and will notify the staff if my child has been exposed to any communicable disease (including head lice). I will sign a consent form if I want the preschool staff to administer any medications to my child.

I agree that the Just B4 Preschool Centre will release my child only to the people listed on the registration form unless alternative written instructions are given.

I agree that I have read and agree to all policies as laid out in the Just B4 Preschool Centre Parent Handbook.

One month's notice is required to terminate this agreement, if notice is not given, full payment is expected. This contract will be reviewed yearly.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Name (First and Last) ￼ Parent/Guardian’s Signature Date:

|  |
| --- |
| **PERSON(S) AUTHORIZED TO PICK UP CHILD (in addition to parent/guardian listed)** |
| **Name:** | **Relationship:** | **Phone:** |
| **Name:** | **Relationship:** | **Phone:** |
| **Name:** | **Relationship:** | **Phone:** |

|  |
| --- |
| **PERSON(S) NOT AUTHORIZED TO PICK UP CHILD** |
| **Name:** | **Relationship:** | **Phone:** |
| **Name:** | **Relationship:** | **Phone:** |

|  |
| --- |
| **CUSTODY AGREEMENT: YES NO** |
| **IF YES, SUPPLY A COPY OF THE CUSTODY ORDER TO THE FACILITY MANAGER/LICENSEE** |

|  |
| --- |
| **ALTERNATE PERSON(S) TO CALL AND PICK UP CHILD IN CASE OF EMERGENCY** |
| **Name:** | **Relationship:** | **Phone:** |
| **Name:** | **Relationship:** | **Phone:** |

|  |
| --- |
| **GROUP EXPERIENCES** |
| YOUR CHILD’S FAVOURITE TOYS/ACTIVITIES: |
| HAS YOUR CHILD HAD PREVIOUS PLAY GROUP EXPERIENCE YES NOIF SO, HOW DID THEY ADAPT: |
| HOW DOES YOUR CHILD REPOND TO OTHER CHILDREN (i.e. shy, seeks others out) |

|  |
| --- |
| **HEALTH INFORMATION (Please attach a separate sheet if necessary)** |
| REGULAR MEDICATIONS AND REASONS FOR USE: |
| ALLERGIES AND TREATMENTS: |
| INJURY(S), ILLNESS(ES) OR OPERATIONS YOUR CHILD HAS HAAD AND INCLUDE DATES:1. Please describe any concerns/issues regarding your child’s health (seizures, asthma, vision, hearing, etc.)
2. Please describe any concerns you may have regarding your child’s development (hearing, vision, speech, language, behaviors etc.)
3. Describe any specific care regarding A and/or B:
4. Please list any other health care professionals involved in your child’s life (Occupational therapist, Speech and Language, Behavior Interventionist etc.
 |

|  |
| --- |
| **EMOTIONAL WELL-BEING** |
| 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 SMOOTHER? |

|  |
| --- |
| **FAMILY AND HOUSEHOLD INFORMATION** |
| PLEASE LIST THE NAMES/ROLES OF SIGNIFICANT PEOPLE IN YOUR CHILD’S LIFE (GRANDPARENTS, SIBLINGS ETC.)? |
| PLEASE DESCRIBE THE GUIDANCE AND DISCIPLINE METHOD USED AT HOME? |
| PRIMARY LANGUAGE SPOKEN IN THE HOME?OTHER LANGUAGES? |

|  |
| --- |
| **ANY OTHER COMMENTS** |

|  |
| --- |
| **SIGNATURE OF PARENT OR GUARDIAN PROVIDING INFORMATION** |
| SIGNATURE: | PRINT NAME: | DATE: |

|  |
| --- |
| **FACILITY USE ONLY** |
| Staff person reviewing family’s documents: |
| SIGNATURE: | PRINT NAME: | DATE: |
| CHILD’S WITHDRAWAL DATE: | REASON FOR WITHDRAWAL: |

**ADDITIONAL CHILD HISTORY (OPTIONAL)**

|  |
| --- |
| **EATING AND NUTRITION** |
| LIST YOUR CHILD’S FAVOURITE FOOD: |
| LIST ANY DISLIKED FOOD? |
| PLEASE DESCRIBE ANY PARTICULAR EATING PATTERNS: |
| ARE THERE ANY CULTURAL OR RELIGIOUS OBSERVANCES RELATED TO FOODS? |

|  |
| --- |
| **TOILETING** |
| IS YOUR CHILD INDEPENDENT IN THE BATHROOM? YES NO |
| DESCRIBE ASSISTANCE NEEDED FOR TOILETING: |
| PLEASE DESCRIBE YOUR CHILD’S PATTERNS FOR TOILETING: |

|  |
| --- |
| **ADMINISTRATION OF MEDICATION** |
| CHILD’S NAME: |
| PHYSICIAN’S NAME: | PHONE NUMBER: |
| PHARMACY NAME: | PHONE NUMBER: |
| MEDICATION: | PRESCRIPTION #: |
| DOSAGE OF MEDICATION | HAS IT BEEN ADMINISTERED PREVIOUSLY? YES NO |
| HAS CHILD RECEIVED THIS MEDICATION FOR 24HR PRIOR TO RETURNING: YES NO |
| TIMES TO BE GIVEN BY GUARDIAN: |
| TIMES TO BE GIVEN BY CARE PROVIDER: |
| ANY POSSIBLE SIDE-EFFECTS TO WATCH FOR AS NOTED BY PHARMACY OR PHYSICIAN? |

|  |
| --- |
| *I hereby give permission and authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* *to**administer the medication in the dosage as stated above. This dosage is consistent with the recommendations of the Physician and/or drug manufacturer. I accept the responsibility of supplying the current correct medication in its original container, and I agree to submit a new consent form if there is any change in the medication to be administered.* |

**CAREGIVER’S ADMINISTRATION RECORD**

|  |  |  |  |
| --- | --- | --- | --- |
| **DATE** | **TIME GIVEN** | **DOSAGE GIVEN** | **ADMINISTERED BY** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |