



Enrollment for Prescott and Russell Licensed Home Child Care Agency

Child

Name: _____ Gender: _____

Date of birth (d/m/y): _____

Parent-1

Name: _____ Date of birth (d/m/y): _____

Home address: _____

City: _____ Postal Code: _____

Cell #: _____ Other #: _____

Email address: _____

Work address: _____

Telephone #: _____

Parent-2

Name: _____ Date of birth (d/m/y): _____

Same address as Parent-1

Home address: _____

City: _____ Postal Code: _____

Cell #: _____ Other #: _____

Email address: _____

Work address: _____

Telephone #: _____

Child lives with:

- Both parents Mother only
- Father only Other: _____

Care preferred in which language?

- French English

Attendance

Date of care needed: _____

- Day Half day

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<input type="checkbox"/> AM	<input type="checkbox"/> AM	<input type="checkbox"/> AM	<input type="checkbox"/> AM	<input type="checkbox"/> AM	<input type="checkbox"/> AM	<input type="checkbox"/> AM
<input type="checkbox"/> PM	<input type="checkbox"/> PM	<input type="checkbox"/> PM	<input type="checkbox"/> PM	<input type="checkbox"/> PM	<input type="checkbox"/> PM	<input type="checkbox"/> PM

Drop-off time: _____ Pick-up time: _____

Preferred Areas:

In Case of Emergency

Name of person to be contacted if parents cannot be reached in case of an emergency during the hours of care:

_____ Telephone #: _____

Persons, other than parents, to whom the child may be released:

- 1. _____ 2. _____
- 3. _____ 4. _____

Medical Information

Child's family physician: _____

Address: _____ City: _____

Telephone #: _____

All children enrolled in authorized Child Care programs must be immunized as recommended by the local medical officer of health, unless otherwise exempted.

Please attach a copy of your child's immunization record.

1. **Special medical conditions:** Yes No

If you checked yes, please specify;

2. **Child's allergies:** Yes No

If you checked yes, please specify; _____

For each child with an anaphylactic allergy, with your participation, the development of an individual plan that includes emergency procedures applicable to the child must be filled out.

3. **Food intolerance:** Yes No

If you checked yes, please specify; _____

4. **Symptoms of child's ill health** (*indicate child's usual reaction to illness; e.g., high temperature, flushing, vomiting, irritability...*).

5. **Medical treatment, drug or medication to be administered during child care hours:** Yes No

Written and signed instructions must be provided by a parent of the child

If you checked yes, please specify : _____

Additional information

Please share with us some additional information about your child
(*e.g., child's habits, toilet routine, favourite activities, routines, fears, etc.*)

Parent's signature: _____ Date: _____

For office use

Date of admission: _____ **Date of discharge:** _____

Prescott and Russell Early Years Services
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