



Registration Form

For office use only:

Date of Enrollment: _____

Date of Withdrawal: _____

- Program Type:** Out of School Care AM PM AM & PM
 Preschool (8:30-11:30) M-W-F T-TH M-T-W-TH-F
 Daycare FT PT Drop In

Personal Information

Full Name of Child: _____ Gender: _____

Name Child Responds To: _____ Date of Birth: _____

Address Street: _____

City: _____

Postal Code: _____

Parent Information

Name of primary parent/guardian of the child: _____

Mother's Name: _____ Place of Employment: _____

Home Phone: _____ Work Number: _____

Cell Number: _____ Email Address: _____

Address (if different from child's): _____

Father's Name: _____ Place of Employment: _____

Home Phone: _____ Work Number: _____

Cell Number: _____ Email Address: _____

Address (if different from child's): _____

Persons Authorized to Pick up Child (other than parents listed above)

- 1) **Name:** _____ **Relationship:** _____
Home Number: _____ **Work/Cell Number:** _____
- 2) **Name:** _____ **Relationship:** _____
Home Number: _____ **Work/Cell Number:** _____
- 3) **Name:** _____ **Relationship:** _____
Home Number: _____ **Work/Cell Number:** _____

Emergency Contact (other than parents listed above)

- 1) **Name:** _____ **Relationship:** _____
Home Number: _____ **Work/Cell Number:** _____
- 2) **Name:** _____ **Relationship:** _____
Home Number: _____ **Work/Cell Number:** _____
- 3) **Name:** _____ **Relationship:** _____
Home Number: _____ **Work/Cell Number:** _____

Persons NOT authorized to pick up your child

- 1) **Name:** _____ **Relationship:** _____
Home Number: _____ **Work/Cell Number:** _____
- 2) **Name:** _____ **Relationship:** _____
Home Number: _____ **Work/Cell Number:** _____

****Please note:** If there is a Custody Agreement, please give details below. A copy of the custody order must be left with the centre's manager.

Emergency Health Information

Doctor's Name/Clinic: _____ Phone Number: _____

Child's Care Card Number: _____

Dentist's Name/Clinic: _____ Phone Number: _____

Consent for Emergency Care

I _____ authorize the staff of Angels Academy Child Care to call a medical practitioner or ambulance in the case of accident or illness of my child, if the parents or emergency contacts cannot be reached immediately.

Signature of Parent: _____ Date: _____

Health Information (If applicable an additional form will be provided to complete)

1) Regular medication (s) and reasons for (please list): _____

2) Allergies/Reactions and treatment (please list): _____

3) Any concerns/issues regarding your child's health (seizures, asthma, vision, hearing, etc) (please list and describe):

Immunization Records

Is your child's immunizations up to date? Yes No

Please attach a copy of your child's immunization records

I have chosen not to immunize my child _____. I understand that my child will not be able to attend Angels Academy if there is a reportable communicable disease.

Parent Signature

Permission for Emergency Vehicle Use

I hereby give permission to Angels Academy to transport my child _____
in their personal vehicle in the case of an emergency.

Parent Signature

Permission for Photo Release

I hereby give permission to Angels Academy Staff to take photos or videos of
my child _____ that will be published in the centre & on Angels Academy
Childcare Centre Facebook page or Centre marketing materials.

Parent Signature

Group Interactions

1) Has your child had previous Daycare experiences? If yes, how did he/she adapt?

2) What is/are your child's favorite toys/activities? _____

3) How does your child behave around other children (seeks others out, feels shy, etc)?

Emotional

1) How does your child react when left with unfamiliar people and/or in unfamiliar situations?

2) What suggestions do you have that would help staff ease your child's transition into the
program? _____

Family Information

1) Please list the name(s) of the significant people in your child's life (siblings, grandparents, etc):

2) Primary language spoken at home:

3) Other languages spoken at home:

4) Any other details you would like to share with us: _____

Toileting

Is your child toilet trained? Yes No Partially

Describe assistance needed for toileting: _____

Details/requirements useful to staff who will assist your child in toilet training: _____

Nap/Rest time

Does your child require a nap? Yes No

What is the duration of nap time your child can have? _____

Dietary Restrictions/Requirements

List your child's favourite foods: _____

List any disliked foods: _____

List any other related details: _____

I hereby authorize that I have read and completely filled out this application and allow the staff to use the information listed.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Angels Academy Manager Signature

Date

Permission for Signing School Age Care Children In/Out

I _____ give permission for the staff of Angels Academy to sign my child _____ in/out for the purpose of to/from and school & daycare.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Child's Name: _____

Outdoor play is a part of our curriculum. To minimize the risks of sun exposure we recommend that you provide your child with a wide brim sun hat to wear and provide sunscreen from home that educators can apply to your child's skin before playing outdoors. Your child's educators will use their discretion upon when sunscreen should be applied to children before outdoor play based on the weather conditions of the day and the season of the year. All products that you supply for your child will be clearly labelled with your child's name.

Sunscreen will not be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed by staff will be reported promptly to the parent/guardian.

I have checked all the applicable information regarding the type and use of sunscreen for my child.

- I give permission for the educators of my child to apply sunscreen before going outside to play in the sun.
- I have provided the following brand/type/expiry date of sunscreen for use on my child

Name of Sunscreen and SPF #:

Expiry Date:

-
- I give permission for the educators of my child to use the sunscreen from the centre following the directions or recommendations on the bottle in the case of my child not having sunscreen at the centre.
 - I understand that sunscreen may be applied to exposed skin, including but not limited to the face (except eyelids), tops of ears, nose, bare shoulders, arms and legs.
 - For medical reasons or other reasons, please do NOT apply sunscreen to the following areas of my child's body:

-
- I do not know of any allergies my child has to sunscreen

Parent's Name (Please Print)

Date:

Parent Signature

Please note: This form is in effect for all the years that your child attends Angels Academy programs unless you submit a new form.

ANGELS ACADEMY CHILDCARE CENTRE EMERGENCY CONSENT CARD

Child's Name: _____ **Birthdate:** _____

Address: _____ **Gender of Child:** _____

Parent's Name: _____ **Child lives with:** _____

Phone #1: _____ **Phone #2:** _____

Parent's Name: _____

Phone #1: _____ **Phone #2:** _____

Emergency Contact: _____ **Phone:** _____

Child's Doctor: _____ **Phone:** _____

1) **Allergies** _____

2) **Medications** _____

Care Card #: _____

CONSENT FORM

It is the policy of this centre to notify a parent when a child is ill or needs medical attention. In the event we cannot contact you and we need to get immediate help for your child, we require a signed consent to do so.

1. I give consent for my child to be taken to the nearest emergency medical centre when I cannot be contacted.

2. I give consent for my child to receive medical treatment.



Hair Color: _____

Skin Color: _____

Eye Color: _____

Parent/Guardian Signature

Parent/Guardian Signature

Witness

Date

Pre-Authorized Debit Agreement for
OUR LADY OF LOURDES ELEMENTARY SCHOOL – ANGELS ACADEMY CHILDCARE CENTRE
2547 Hebert Road, West Kelowna, BC V4T 2J6
Phone: 250-768-9008 • Fax: 250-768-0168

Payer (Parent) Name: _____ Date: _____

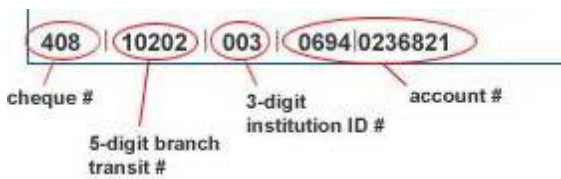
Payer Billing Address: _____

Account Information

My account is new on file:

Bank Name: _____ Transit # (5digits): _____

Institution ID # (3digits): _____ Account #: _____



My account information is the same as the previous school year. (Void cheque/bank info not necessary.)

Pre-Authorized Debit Details

I, the Payer, authorize Our Lady of Lourdes Elementary School, and the financial institution designated (or any other financial institution I may authorize at any time) to begin deductions as per my instructions for payments and/or any other outstanding amounts due from time to time. I understand that the Roman Catholic Bishop of Nelson will administer this PAD Agreement. These services are for personal use.

Regular monthly payments for the full amount of fees will be debited to (i.e. withdrawn from) my specified account on or about the first day of the month. I may revoke my authorization at any time subject to providing at least 30 days written notice. To obtain a sample cancellation form or more information on my right to cancel a PAD agreement, I will contact my financial institution or visit www.cdnpay.ca. Signature

Signature of Account Holder: _____ Signature of Joint Account Holder (if applicable): _____

Name (print): _____ Name (print): _____

Date: _____ Date: _____

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on the Payer's recourse rights, I may contact my financial institution or visit www.cdnpay.ca.