ST. PATRICK'S ELEMENTARY SCHOOL

St. Patrick's Preschool APPLICATION FORM 2026-2027

Child's Full Name: _____ **Birthday:** _____
Address: _____
Home Phone Number: _____

Mother's Name: _____ **Mother's Cell Number:** _____
Work Phone Number:_____ **Home:**_____
_____

Father's Name: _____ **Father's Cell Number:** _____
Work Phone Number:_____ **Home:**_____
_____

Parish Were Registered: _____ **Envelope Number:** _____
Official Tax Receipt Payable to: _____

REGISTRATION REQUIREMENTS

Please attach Photocopies of the following documents:

_____ **$75.00 Registration Fee – NON-REFUNDABLE**
_____ **Birth Certificate**
_____ **Baptismal Certificate**

PAYMENT DUE UPON ACCEPTANCE:

(**Pre-Authorized Debit form**)
_____ **September tuition (withdrawn March 15th) Non-Refundable**
_____ **Tuition (PAD)**
_____ **Emergency Prep. Fee $40.00**

PLEASE CHECK YOUR PROGRAM PREFERENCE:

2 Days: Tuesday/Thursday:			
3 Days: Monday/Wednesday/Friday			
5 Days: Monday-Friday			

OFFICE USE ONLY			
Registration Fees ($75.00)		**Tuition Rate:**	
Emergency Fee ($40.00)		**Date Received:**	

St. Patrick's Preschool

PARENT HANDBOOK ACKNOWLEDGEMENT FORM

Child's Name: _____

I _____ acknowledge that I have read and understand the information in the St. Patrick's
(parents' full name)

Preschool Parent Handbook.

Parent or Guardian's Name (please print): _____

Parent or Guardian Signature: _____

Date: _____

Neighbourhood Walks Permission Form

I permit my child _____ to go on supervised neighbourhood walks with the staff of St. Patrick's Preschool during preschool hours for the current preschool year. These neighbourhood walks might occur for one of the following reasons:

- Nature walks
- Physical exercise
- Learning about our environment

Parent or Guardian's Name (please print): _____

Parent or Guardian Signature: _____

Date: _____

PERSONAL INFORMATION PRIVACY ACT CONSENT FORM

1. I consent to having St. Patrick's Preschool collect personal information that may include student identification information, birth certificate, legal guardianship, court orders if applicable, parents' work numbers and e-mail address, behavioural and health information, emergency contact name and number, doctors' names and numbers, health insurance numbers and any similar information needed for registration. This information is required to register your child at this school and assist the school in making an informed decision as to your child's suitability and appropriate placement in the school.
   It will also allow the school to respond immediately to an emergency. For information, the privacy manager for St. Patrick's Elementary School is Mrs. Evans and may be reached at 604-879-4411.

2. I consent to having work samples and photographs of my child(ren) used by St. Patrick's Preschool on the school website, newsletters and other promotional material.
3. I consent to having photographs and work samples of my child(ren) used by St. Patrick's Preschool in the school yearbook.
4. The school may prepare a family phone list for class lists and telephone trees.
5. The school may release any pertinent information to St. Patrick's Parish (ie: names, addresses, phone contact numbers, etc.)

(Please Print)

Family Name: _____

Child's Name: _____

Date: _____

Parent Signature: _____

ST. PATRICK'S ELEMENTARY SCHOOL

Pre-Authorized Debit Authorization Form (PAD) and Electronic Funds Transfers (EFTs)
Agreement for 2026-2027 Tuition and Fee Payments

Student Information: **PLEASE PRINT**

1. _____ _____ _____
Last Name **First Name** **Entering Grade**

2. _____ _____ _____
Last Name **First Name** **Entering Grade**

INSTRUCTIONS:

1. Please complete all sections in order to instruct your financial institution to make payments directly from your account.
2. Please sign the Terms and Conditions on the reverse of this document.
3. Return the completed form with a blank cheque marked "**VOID**" or have your financial institution provide a form with your bank account information if you have changed your financial institution and or accounts.

Payee Information: **PLEASE PRINT**

Last Name of Account Holder	**First Name of Account Holder**	**Email Address**	**Phone Number**
Home Address	**City**	**Province**	**Postal Code**

Bank Account Information:

Name of Financial Institution	**Institution No.**	**Transit No.**	**Account No.**

☐ **No changes to account, use the same account as the previous year.**

Parish Where Registered	**Envelope Number**	**Tax Receipt Should be Made Out to:**

Note: If not indicated you will be charged non-parishioner rates

Pre-Authorization Debit (PAD)

I/We authorize Saint Patrick's Elementary School to debit my/our account with the aforementioned financial institutions as indicated above, for the purpose of monthly tuition fees and miscellaneous payments. In the event that a payment is returned, I/we also authorize the school to re-submit the payment plus an administrative fee NSF of **$20.00**
In order to facilitate any changes to your bank account, the school office must receive the information in writing at least 10 days prior to the tuition withdrawal date.

TUITION: (Please initial)

____ Pre-authorization is given for 9 monthly debits in the amount of $_____ for the months of October 1, 2026 to June 1, 2027 inclusive. For all student(s), please note that school fees for the month of September withdrawn via PAD March 15th 2026 and are non-refundable. Other Debits will take place on the first (1st) day of each month or the next business day.

Other Incidentals: (Please initial)

St. Patrick's Elementary School will introduce the use of incidentals PAD fees effective from 1 September 2020 to collect incidental fees from families. In practical terms what this means is that when the school notifies you of an incidental fee for your child (for example, a field trip fee, year book fee) that these funds **will be debited directly** from your bank account by the school. We are introducing this process to help automate our payments processing and reduce the need to handle physical cash/ cheques. In order to do this, we require your authorization **and a copy of a void cheque**.

Please note that St. Patrick's Elementary School will only withdraw the specified amount after first having notified you of the amount and purpose for which the fee is being levied and the date that the funds will be debited from your account. In introducing this payment process we will reduce substantially the school's overhead (collecting physical cash, the depositing of such cash at the bank, its reconciliation not to mention avoiding cases where a child might lose the money on the way to school).

☐ I, consent to St. Patrick's Elementary School debiting from my bank account payment for incidental activities related to my child's education that occur during the course of the 2026-27 school year recognizing that the school will only do so after first informing me of the activity, its cost and the date the funds will be withdrawn from my account.

_____	_____	_____
Name of Account Holder	Signature	Date
_____	_____	_____
Name of Account Holder	Signature	Date

PAYOR'S PAD AGREEMENT PERSONAL PRE-AUTHORIZED DEBIT PLAN

Terms & Conditions

1. In this Agreement, "I", "me" and "my" refers to each Account Holder who signs below.
2. I agree to participate in this Pre-Authorized Debit Plan for personal/household or consumer purposes and I authorize the Payee indicated on the reverse hereof and any successor or assign of the Payee to draw a debit in paper, electronic or other form for the purpose of making payment for consumer goods or services (a "Personal PAD"), on my account indicated on the reverse hereof (the "Account") at the financial institution indicated on the reverse hereof (the "Financial Institution") and I authorize the Financial Institution to honour and pay such debits. This Agreement is provided for the benefit of the Payee and my Financial Institution and is provided in consideration of my Financial Institution agreeing to process debits against my Account in accordance with the Rules and the Canadian Payments Association. I agree that any direction I may provide to draw a Personal PAD, and any Rules of the Canadian Payments Association. I agree that any direction I may provide to draw a Personal PAD, and any Personal PAD drawn in accordance with this Agreement, shall be binding on me as if signed by me, and, in the case of paper debits, as if they were cheques signed by me.
3. I may revoke or cancel this Agreement at any time upon notice being provided by me either in writing. I acknowledge that in order to revoke or cancel the Agreement provided in this Agreement, I must provide notice or revocation or cancellation to the Payee. This Agreement applies only to the method of payment and I agree that revocation or cancellation of this Agreement does not terminate or otherwise have any bearing on any contract that exists between me and the Payee.
4. I agree that my Financial Institution is not required to verify that any Personal PAD has been drawn in accordance with this Agreement, including the amount, frequency and fulfillment of any purpose of any Personal PAD.
5. I agree that delivery of this Agreement to the Payee constitutes delivery by me to my Financial Institution. I agree that the Payee may deliver this Agreement to the Payee's financial institution and agree to the disclosure of any personal information which may be contained in this Agreement to such financial institution.
6. I understand that with respect to:
   (a) fixed amount Personal PADs occurring at set intervals, I shall receive written notice from the Payee of the amount to be debited and the due date(s) of debiting, at least ten (10) calendar days before the due date of the first Personal PAD, and such notice shall be received every time there is a change in the amount or payment dates(s); or
   (b) variable amount Personal PADs occurring at set intervals, I shall receive written notice from the Payee of the amount to be debited and the due date(s) of debiting, at least ten (10) calendar days before the due date of every Personal PAD.
   (c) Fixed amount and variable amount Personal PADs occurring at set intervals, where the Personal PAD Plan provides for the change in the amount of such fixed and variable amount PADs as a result of my direct action (such as, but not limited to, a telephone instruction) requesting the Payee to change the amount of a PAD, no pre-notification of such changes is required.

   OR

   (d) I agree to either waive the pre-notification requirements in section 6(a) of this Agreement or to abide by any modification to the pre-notification requirements as agreed to with the Payee.
7. I agree that with respect to Personal PADs, where the payment frequency is sporadic, a password or secret code or other signature equivalent will be issued and shall constitute valid Agreement for the Payee or its agent to debit my account.

8. I may dispute a Personal PAD by providing a signed declaration to my Financial Institution under the following conditions:
   (a) the Personal PAD was not drawn in accordance with this Agreement;
   (b) this Agreement was revoked or cancelled; or
   (c) any pre-notification required by section 6(b) was not received by me.
   I acknowledge that in order to obtain reimbursement from my Financial Institution for the amount of a disputed Personal PAD, I must sign a declaration to the effect that either (a), (b) or (c) above took place and present it to my Financial Institution up to and including but not later than ninety (90) calendar days after the date of which the disputed Personal PAD I must sign a declaration to the effect that either (a), (b) or (c) above took place and present it to my Financial Institution up to and including but not later than ninety (90) calendar days after the date on which the disputed Personal PAD was posted to my Account. I acknowledge that, after this ninety (90) day period, I shall resolve any dispute regarding a Personal PAD solely with the Payee, and that my Financial Institution shall have no liability to me respecting any such disputed Personal PAD.
9. I certify that all information provided with respect to the Account is accurate and I agree to inform the Payee, in writing, of any change in the Account information provided in this Agreement at least ten (10) business days prior to the next due date of a Personal PAD. In the event of any such change, this Agreement shall continue in respect of any new account to be used for Personal PADs.
10. I warrant and guarantee that all persons whose signatures are required to sign on the Account have signed this Agreement below. In addition, I warrant and guarantee, where applicable, that I have the authority to electronically agree to commit to this Agreement by secure electronic signature and that my secure electronic signature conforms with the requirements of Rule H1.
11. I understand and agree to the foregoing terms and conditions.
12. I agree to comply with the Rules of the Canadian Payments Association or any other rules or regulations which may affect the services described herein, as may be introduced in the future or are currently in effect and I agree to execute any further documentation which may be prescribed from time to time by the Canadian Payments Association in respect of the services described herein.
13. Applicable to the Province of Quebec only: It is the express wish of the parties that this Agreement and any related documents be drawn up and executed in English. Les parties conviennent que la présente Agreement et tous les documents s'y rattachant soiont rédigés et signée en anglais.

_____	_____	_____
Name of Account Holder	Signature	Date
_____	_____	_____
Name of Account Holder	Signature	Date

Vancouver Coastal Health
Promoting wellness. Ensuring care.

IMMUNIZATION (VACCINATION) INFORMATION FOR CHILDCARE

Important: Please complete and return this form to your childcare facility. If you wish to complete this information online go to www.vch.ca/child-immunization-report

Dear Parent/ Guardian:

All childcare facilities in BC are required by law under the *Community Care and Assisted Living Act* to keep a record of each child's immunization history. These records are required to be made available to Vancouver Coastal Health Authority (VCH) medical health officers for public health programs. The information you provide on this form will be used to update your child's health record at VCH in order that: medical health officers may respond if a disease outbreak occurs in your childcare facility; public health staff can recommend immunizations which your child may be missing; and VCH is able to provide better care to your child as part of its public health programs.

PART A: CHILD AND FAMILY INFORMATION ****PLEASE PRINT CLEARLY****

Today's Date											
Childcare Facility Name											
Child's Name Surname		Given Name					Preferred Name				
SEX	**Birthdate** dd mm yyyy			**Birth Place** City		Province		Country			
Child's personal health number (BC Care Card)											
Home Address			**Postal Code**		**Home Phone**						

Health Care Provider's Name	**HCP Phone #**

	PARENT/GUARDIAN – FIRST CONTACT	**PARENT/GUARDIAN – SECOND CONTACT**
First Name		
Last Name		
Preferred Phone		
Text		
Email Address		

PART B: CHILD'S VACCINATION INFORMATION

1. Has your child had chickenpox disease at 12 months of age or older?

√ check the correct answer ☐ **Yes** ☐ **No** ☐ **Not Sure**

Children who have had chickenpox disease on or after 12 months of age are considered to have life-long immunity to chickenpox disease and do not require vaccination against chickenpox disease. Children who have not had chickenpox disease on or after 12 months of age (this includes children who had disease younger than 12 months of age) need 2 doses of chickenpox vaccine. Dose 1 should be received at 12 months of age and dose 2 should be received before entering kindergarten.

2. ATTACH A PHOTOCOPY **of your child's vaccination record to this form.**

For example: BC Child Health Passport OR immunization record. **Attach a copy of the original record** as it appears in English or any language. Ensure your child's name and date of birth are written on each page.

Please turn over for more information

THIS IS AN IMPORTANT NOTICE.
PLEASE HAVE SOMEONE TRANSLATE IT.

AMHARIC *(Ethiopia)*	ይህ ጠቃሚ ማስታወቅያ ነው:: እባክዎን ሌላ ሰው- ያስተርጉምልዎት::
BURMESE	ဤစာသည်အရေးကြီးသောသတိပေးအကြောင်းကြားစာဖြစ်ပါသည်။ ကျေးဇူးပြု၍တစ်ယောက် ယောက်ကိုဘာသာပြန်ခိုင်းပါ။
CHINESE	這是一份重要通告，請找人爲您翻譯。
CROATIAN	OVO JE VAŽNO OBAVJEŠTENJE. ZAMOLITE NEKOGA DA VAM GA PREVEDE.
FRENCH	CECI EST UN AVIS IMPORTANT. PRIERE DE LE FAIRE TRADUIRE.
HINDI	यह एक बहुत ज़रुरी सूचना है। कृपया किसी से इसका अनुवाद करा लें।
ITALIAN	QUESTO È UN AVVISO IMPORTANTE. SIETE PREGATI DI FARVELO TRADURRE DA QUALCUNO.
KHMER *(Cambodia)*	នេះគឺជាសេចក្តីប្រកាសដ៏សំខាន់មួយ សូមអ្នករកអ្នកបកប្រែជូនអ្នក ។
KOREAN	중요한 안내사항입니다. 번역을 할 수 있는 분에게 도움을 청하시기 바랍니다.
PERSIAN *(Iran)*	.این یک اطلاعیهٔ مهم است. لطفا از کسی بخواهید آن را برای شما ترجمه کند
POLISH	TO JEST WAŻNE ZAWIADOMIENIE. POPROŚ KOGOŚ ABY JE PRZETŁUMACZYŁ.
PUNJABI	ਇਹ ਇਕ ਜ਼ਰੂਰੀ ਸੂਚਨਾ ਹੈ। ਕਿਰਪਾ ਕਰਕੇ ਕਿਸੇ ਕੋਲੋਂ ਇਸ ਦਾ ਉਲੱਥਾ ਕਰਵਾ ਲਵੋ।
SERBIAN	OVO JE VAŽNO OBAVEŠTENJE. ZAMOLITE NEKOGA DA VAM GA PREVEDE.
SOMALI	KANI WAA OGEYSIIS MUHIIM AH. FADLAN QOF HA KUU TURJUMO.
SPANISH	ÉSTE ES UN AVISO IMPORTANTE. POR FAVOR, BUSQUE A ALGUIEN QUE SE LO TRADUZCA.
TAGALOG *(Philippines)*	ITO AY ISANG MAHALAGANG PAUNAWA. MANGYARING IPASALIN ITO PARA MAUNAWAAN.
VIETNAMESE	ĐÂY LÀ THÔNG BÁO QUAN TRỌNG. HÃY NHỜ NGƯỜI DỊCH GIÚP.

Personal information on this form is collected, used and disclosed by VCH in accordance with the *Freedom of Information and Protection of Privacy Act*. Statistical information may be provided to the Ministry of Health for healthcare planning, program evaluation and quality improvement purposes. We may contact you in the future to ask whether you would like to participate in the evaluation of the school immunization program. VCH may need to email or text you information relating to your child's immunizations. Please be aware that your personal information may be stored outside of Canada by your email/messaging service provider and will be subject to the laws of that jurisdiction. If you have any questions about privacy, please contact VCH's Information Privacy Office at 604.875.5568 or privacy@vch.ca.

If you have any questions about immunizations or the collection and use of this information, or you would like to withdraw your consent to receive emails or texts, contact your local public health nurse at the community health centre near you – see list below.

For vaccination schedules and more information go to www.vch.ca or www.immunizebc.ca

Community Health Centres in Vancouver Coastal Health

Vancouver					
Evergreen 3425 Crowley Dr 604.872.2511	**Raven Song** 2450 Ontario St 604.709.6400	**Robert and Lily Lee Family** 1669 East Broadway 604.675.3980	**Pacific Spirit** 2110 West 43rd Ave 604.261.6366	**South** 6405 Knight St 604.321.6151	**Three Bridges** 1290 Hornby St 604.736.9844
Richmond	**North and West Vancouver**	**Squamish**	**Whistler**	**Pemberton**	
8100 Granville Ave 604.233.3150	604.983.6700	1140 Hunter Place 604.892.2293 or 1.877.892.2231	202 - 4380 Lorimer Rd 604.932.3202	1403 Portage Road 604.894.6939	
Coastal					
Gibsons	**Sechelt**	**Pender Harbour**	**Powell River**		
494 South Fletcher Rd 604.886.5600	5571 Inlet Ave 604.885.5164	5066 Francis Peninsula Rd 604.883.2764	3rd Floor, 5000 Joyce Ave 604.485.3310		
Central Coast					
Bella Bella	**Bella Coola**				
250.957.2308 ext 229	250.799.5722				

Anaphylaxis Emergency Action Plan

Child's Name: _____ Grade:____ Div: _____ Birthdate:_____

School Name: St. Patrick's Elementary School School Address: 2850 Quebec St. Vancouver B.C. V5T 3A9 School Phone: 604 879 4411

THIS PERSON HAS A POTENTIALLY LIFE THREATENING ALLERGY (ANAPHYLAXIS)

Allergy trigger(s):

☐ Food(s): _____

_____

_____

☐ Insect Stings: _____

☐ Other: _____

Medication:

☐ EpiPen Jr. (0.15mg) ☐ EpiPen Sr. (0.3mg)

Location:_____ Expiry:_____

ACT QUICKLY. DO NOT WAIT FOR SYMPTOMS TO GET WORSE OR NEW SYMPTOMS TO BEGIN

- **Give Epinephrine** at the first sign of an anaphylactic reaction.
- **Call 9-1-1**
- **Call Emergency Contact**

Epinephrine is the first line medication for the emergency management of anaphylaxis. **Antihistamines (e.g. Benedryl ™) or asthma medication should not be used to treat anaphylaxis.**

AN ANAPHYLACTIC REACTION MAY HAVE THE FOLLOWING SIGNS AND SYMPTOMS:

Face: Hives, itching, swelling (lips, face, tongue) flushed face or body

Airway: Difficulty breathing, swallowing or speaking, coughing , wheezing, change of voice, sneezing

Stomach: Stomach cramps, nausea, vomiting, diarrhea

Total body: Hives, itching, swelling, weakness, dizziness, loss of consciousness, anxiety, feeling of doom

EMERGENCY CONTACT INFO:

Name	Relationship	Cell Phone	Other Phone

The undersigned parent/guardian authorizes any adult to administer emergency medication following the instructions outlined above to the above named person in the event of an anaphylactic reaction, as described above. This protocol has been recommended by a physician/NP. The plan will be shared with appropriate facility/school personnel to assist in responding in an Emergency. It is the parent/guardian's responsibility to advise the school about any changes to this plan.

_____ _____ _____ _____

Parent/Guardian Date Doctor/NP Signature Date

Anaphylaxis Emergency Plan is provided as a resource from Vancouver Coastal Health – April 2019
Adapted from the Anaphylaxis Emergency Plan on www.foodallergycanada.ca

Vancouver School Board

Asthma Emergency Action Plan

Child's Name: _____ Grade:____ Div: _____ Birthdate:_____

School Name: St. Patrick's Elementary School School Address: 2850 Quebec St. Vancouver B.C. V5T 3A9 School Phone: 604 879 4411

THIS PERSON HAS A SERIOUS (POTENTIALLY LIFE-THREATENING) ASTHMA ATTACKS

Asthma trigger(s):

- ☐ Food(s): _____
- ☐ Animal(s): _____
- ☐ Environment: _____
- ☐ Other: _____

Emergency Medication Information:

Medication Name: _____

Expiry Date:_____ Location:_____

☐ **Previous asthma attack requiring hospitalization**: Person is at greater risk

☐ **Previous Anaphylaxis:** If student has/is having difficulty breathing, give epinephrine auto-injector before asthma medication

ACT QUICKLY; GIVE EMERGENCY MEDICATION IMMEDIATELY

1. **Give Emergency Medication Instructions:**

_____

_____

_____

2. **If symptoms worsen or do not improve:**

   ➔ **CALL 9-1-1**

3. **Call emergency contact**

AN ASTHMA ATTACK MAY HAVE THE FOLLOWING SIGNS & SYMPTOMS

- Coughing
- Wheezing
- Tightness or pain in chest
- Unable to complete sentences due to shortness of breath
- Fast/shallow breathing
- Fear or anxiety
- Blue lips or nail beds
- Sweating

EMERGENCY CONTACT INFO:

Name	Relationship	Cell Phone	Other Phone

The undersigned parent/guardian authorizes any adult to administer emergency medication following the instructions outlined above to the above named student in the event of an asthma attack. This protocol has been recommended by the student's Doctor/Nurse Practitioner. It is the parent/guardian's responsibility to advise the school about any changes to this plan.

_____ _____ _____ _____

Parent/Guardian Date Doctor/NP Signature Date

Asthma Emergency Plan is provided as a resource from Vancouver Coastal Health – April 2019
First aid information adapted from www.asthma.ca

Vancouver School Board

Please attach child's photo to this form.

CHILD CARE

CCFL3, Rev 04-2009

EMERGENCY CONSENT FORM

CHILD'S NAME: _____ BIRTHDATE: _____
SURNAME FIRST NAME(S) YEAR/MONTH/DAY

ADDRESS: _____

PARENT'S NAME: _____ HOME PHONE: _____

CELL PHONE: _____ WORK PHONE: _____

PARENT'S NAME: _____ HOME PHONE: _____

CELL PHONE: _____ WORK PHONE:_____

EMERGENCY CONTACT: _____ CELL PHONE: _____ PHONE: _____

OUT OF TOWN CONTACT: _____ PHONE: _____

CHILD'S DOCTOR: _____ PHONE: _____

DATE OF MOST RECENT TETANUS SHOT:_____

ALLERGIES / MEDICATIONS: _____

CHILD'S DENTIST: _____ PHONE: _____

CARE CARD NUMBER_____

CONSENT

1) It is the policy of this facility to notify a parent when a child is ill or needs medical attention. Occasionally we cannot contact parents and we need to get immediate help for the child. Our procedure is to call for an ambulance.

2) Please sign the consent below so that we can take the appropriate action on behalf of your child. Return the signed consent to the facility immediately. We will take this consent with us to the emergency centre.

3) I hereby give consent for my child _____ to be taken to the nearest emergency centre when I cannot be contacted.

4) I hereby give consent for my child named above to receive medical treatment.

_____ _____
DATE SIGNATURE OF PARENT / GUARDIAN

_____
WITNESS

CCFL3, Rev 04-2009

Name of Facility:

CHILD'S STARTING DATE: **SEX:** **DATE OF BIRTH:**

_____/ _____/ _____ **M ____ F ____** **_____/ _____/ _____**
YY MM DD **YY MM DD**

NAME OF CHILD: _____
(Surname) (Given Names) (Also Known As)

Name the Child responds to: _____

Address: _____

Postal code: _____ Phone: _____

Person(s) with whom the child lives (adults and children): _____

Child's first language: _____ Other languages: _____

Parent(s) / guardian(s):

Name: _____ Home phone: _____ Cell phone: _____

Work phone: _____ Days/hours of work: _____ E-mail: _____

Name: _____ Home phone: _____ Cell phone: _____

Work phone: _____ Days/hours of work: _____ E-mail: _____

Person(s) authorized to pick up the child and be contacted in case of emergency. These people should be available during hours of care. (include mother / father / guardian):

Name: _____ Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Name: _____ Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Name: _____ Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Name: _____ Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

If appropriate, list an English speaking contact:

Name: _____ Phone: _____

Has the child previously attended daycare/preschool?

YES ☐ NO ☐ Comments: _____

Comments/instructions to help us care for your child. (Please feel free to add additional pages.):

Toileting/Diapering (special words): _____

Rest Time (special comfort – toy/blanket): _____

Eating/Mealtime (include food likes/dislikes): _____

Fears: _____

Please tell us anything else you think will help us provide an enriching experience for your child: _____

_____

_____

HEALTH INFORMATION

Health professionals involved with your child (other than doctor and dentist):

NAME	PROFESSION/AGENCY	
_____	_____	Phone: _____
_____	_____	Phone: _____
_____	_____	Phone: _____

Does your child have:

A medical condition/concern? YES ☐ NO ☐
If yes, please provide further information: _____

Allergies? YES ☐ NO ☐
If yes, please provide further information: _____

Asthma? YES ☐ NO ☐
If yes, please provide further information: _____

Has your child had a seizure in the past year? YES ☐ NO ☐
If yes, please provide further information: _____

Does your child require a special diet related to a medical condition? YES ☐ NO ☐
If yes, please provide further information: _____

Food sensitivities? YES ☐ NO ☐
If yes, please provide further information: _____

List all prescription and "over the counter" medications your child receives:

Medication	Times Given	Reason for Medication
_____	_____	_____
_____	_____	_____

You may be asked to complete additional forms if you answered yes to any of the above.

This health information may be made available to the staff of Vancouver Coastal Health.

Custody Agreement YES ☐ N/A ☐ **Provided to Facility** YES ☐ NO ☐ N/A ☐
Immunization Documents Returned to Facility YES ☐ NO ☐

Information Provided By: _____ _____
Print Name Signature

DATE: _____/_____/_____
YY MM DD

Information Received By: _____ _____
Print Name Signature

DATE: _____/_____/_____
YY MM DD

Office Use Only

Date Child Leaves the Facility: DATE: _____/_____/_____
YY MM DD