Roberts Creek Childcare Society

1150 Timberland Drive, P.O. Box 146

Roberts Creek, BC, V0N 2W6

604 885 0163, admin@robertscreekchildcaresociety.com

Childcare Registration Form

Date of Birth: _____/___/___ Sex: M F

Child Information

Surname:	Given Name:	Middle Name:	
Address:	City/Town:	Postal Code:	
Home Phone:	Child's First Language:	Other Language:	

Parent/Guardian Information

Mothers Name:	E-Mail:	Home Phone #	Cell Phone #
Address: (if different from child)	City/Town:	Postal Code:	
Place of Work:	Days/Hours of Work:	Work Phone #	
Fathers Name:	E-Mail:	Home Phone#	Cell Phone #
Address: (if different from child)	City/Town:	Postal Code:	
Place of Work:	Days/Hours of Work:	Work Phone#:	

Persons Authorized To Pick Up The Child And Be Contacted In Case Of Emergency

Name:	Relationship:	Home Phone#	Cell Phone #
Name:	Relationship:	Home Phone#	Cell Phone#
Name:	Relationship:	Home Phone#	Cell Phone #
Name:	Relationship:	Home Phone#	Cell Phone#

List Out Province Contact Person

Name:	Relationship:	Home Phone#	Cell Phone#

Custody Agreements: Please list any custody agreements we need to be aware of and provide copies.

Other Children Living At Home:

Name:	DOB:	Name:	DOB:
Name:	DOB:	Name:	DOB:

Has Child Previously Attended Day Care/Preschool

Yes / No	Facility:

Health and Nutrition Information:

Toileting concerns and/or comments you wish us to be aware of:

Medical conditions and/or concerns you wish us to be aware of:

Have hearing problems?	Yes No	Take any medications?	Yes No
Have vision problems?	Yes No	Have allergies?	Yes No
Have speech/language problems?	Yes No	Have food sensitivities/intolerances?	Yes No
Require a special diet?	Yes No	Have any health concerns?	Yes No

Please provide further information if you answered yes to any of the above

Immunization History: Please attach a photocopy of immunization record.

Conscientious Objector	Yes No	Medical Exemption	Yes No

Children not protected may be excluded from RCCCS for the duration of a communicable disease outbreak.

Health Information: Please list any health professionals involved with your child

Doctor:	Phone:	Dentist:	Phone:
Other:	Phone:	Other:	Phone:

Care Card / Personal Health Number:

Information Provided By: _____ _____ _____

Printed Name Signature Date

Administration Use Only:

Child's Start Date: _____ Program Enrolled In: _____

Child's Start Date: _____ Program Enrolled In: _____

Child's Last Day: _____