

# Discovery Preschool Registration Form:

BDP  HDP  On 7  UPD

<b>CHILD INFORMATION:</b>				
Last Name:		First Name:		Date of Birth (YY/MM/DD):
Telephone:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Starting Date:	Withdrawal Date:	Does child live with: Mother <input type="checkbox"/> Father <input type="checkbox"/> Both <input type="checkbox"/>
Food Restrictions:				
<b>ALLERGIES:</b>				
Does your child have allergies? Yes <input type="checkbox"/> No <input type="checkbox"/>				
If yes, please indicate below:				
<b>Allergy</b>	<b>Mild-Moderate</b>	<b>Severe</b>	<b>Life Threatening</b>	
If your child has food restrictions or allergies, you will be required to complete <i>Allergy Screening</i> and/or <i>Anaphylactic Alert Notice</i> form prior to start date (please ask supervisor for copy).				
Please indicate if you have completed <i>Allergy Screening</i> : Yes <input type="checkbox"/> No <input type="checkbox"/>				
Please indicate if you have completed <i>Anaphylactic Alert Notice</i> : Yes <input type="checkbox"/> No <input type="checkbox"/>				
Health Concerns: Has your child had any communicable diseases? Yes <input type="checkbox"/> No <input type="checkbox"/>				
If Yes, please provide details: _____				
Has your child been under the guidance of Early Intervention or any other agency related to development, medical or behaviour needs? - (see inclusion policy) Yes <input type="checkbox"/> No <input type="checkbox"/>				
If Yes, please provide details: _____				

<b>PARENT/GUARDIAN CONTACTS:</b>					
Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/>			Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/>		
Last Name:		First Name:		Last Name:	
Home Address:			Home Address:		
City:	Province:	Postal Code:	City:	Province:	Postal Code:
Home Telephone:			Home Telephone:		
Daytime Location (employer, school, home, etc):			Daytime Location (employer, school, home, etc):		
Daytime Address:			Daytime Address:		
Daytime Telephone:			Daytime Telephone:		
Cellular Telephone:			Cellular Telephone:		
Email Address:			Email Address:		

<b>Parent/Guardian Initials</b>	<b>Supervisor Initials:</b>

**PERSONS AUTHORIZED TO PICK UP CHILD:**

I/We authorize ONLY the following persons to pick up my child from the Program (all of whom are over 18 years of age) or act as an emergency contact in the event that I/We cannot be reached: Under no circumstance will your child be released to anyone not listed below without written authorization:

	Persons Name	Relationship	Address:	Daytime Telephone:	Cellular:
1					
2					
3					

Custody Agreement Details (if any):

**MEDICAL INFORMATION:**

Family Doctor:	Phone Number:	
Doctor's Full Address:	City, Province:	Postal Code:
Is your child Immunized?: Yes <input type="checkbox"/> If Yes, proof of child's record of immunization has been provided? Yes <input type="checkbox"/> No <input type="checkbox"/>		
No <input type="checkbox"/> If No, notice of exemption has been provided? Yes <input type="checkbox"/> No <input type="checkbox"/>		

**Call the York Region Community and Health Services Immunization Team at 1-877-794-1880 if your child has not been immunized, or if an exemption is required.**

**Previous Medical History - please indicate all that apply:**

<input type="checkbox"/>	German Measles	<input type="checkbox"/>	Poliomyelitis	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	Small Pox	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Giardia Lamblia
<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Diphtheria
<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	Reaction to bites	<input type="checkbox"/>	Reaction to stings	<input type="checkbox"/>	Whooping Cough

**PARENT/GUARDIAN PERMISSIONS:**

I hereby consent to the collection, use and disclosure of my child's information by the centre for the purpose of providing child care services to my child enrolled in Centre programs. I understand that the Centre protects the privacy of all personal information in its possession in compliance with prevailing privacy legislation. **I acknowledge that enrolment is contingent on all information outlined in these forms being full and accurate.**

Parent/Guardian (Please Print):	Parent/Guardian Signature:	Date:
Supervisor (Please Print):	Supervisor Signature:	Date: