

# Somewhere to "Grow" Montessori

## Preschool and Kindergarten

13590 62nd Avenue, Surrey, BC ☎778-578-0329

1320 7th Avenue, New Westminster, BC ☎604-517-0241

email: stgnewwest@hotmail.com

www.somewheretogrow.com

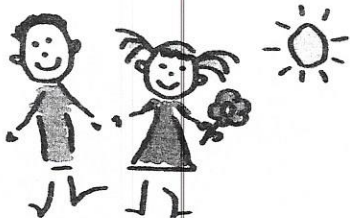
### REGISTRATION FORM FOR CHILD CARE

FACILITY NAME:	
FULL NAME OF CHILD:	USUAL NAME OF CHILD [IF DIFFERENT]:

PERSONAL INFORMATION	
CHILD'S DATE OF BIRTH:	GENDER:      STARTING DATE:
ADDRESS:	POSTAL CODE:
	PHONE: (    )
PARENT OR GUARDIAN:	PARENT OR GUARDIAN:
ADDRESS [IF DIFFERENT FROM ABOVE]:	ADDRESS [IF DIFFERENT FROM ABOVE]:
PHONE:	PHONE:
WORK ADDRESS/ALTERNATE LOCATION:	WORK ADDRESS/ALTERNATE LOCATION:
PHONE [INCLUDE LOCAL]:	PHONE [INCLUDE LOCAL]:
CELLULAR/PAGER:	CELLULAR/PAGER:
HOURS AT THIS LOCATION:	HOURS AT THIS LOCATION:

EMERGENCY HEALTH INFORMATION			
CARE CARD NUMBER:			
FAMILY DOCTOR/CLINIC NAME:		FAMILY DENTIST/CLINIC NAME:	
ADDRESS:	PHONE:	ADDRESS:	PHONE:

CONSENT FOR EMERGENCY CARE	
I authorize the staff at the child care centre to call a medical practitioner or ambulance in the case of accident or illness of my child(ren), if the parent cannot immediately be reached.	
SIGNATURE OF PARENT/GUARDIAN:	DATE:
MANAGER OF FACILITY:	



# Somewhere to "Grow" Montessori Preschool and Kindergarten

PERSON(S) AUTHORIZED TO PICK UP CHILD (other than parent/guardian listed above)		
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

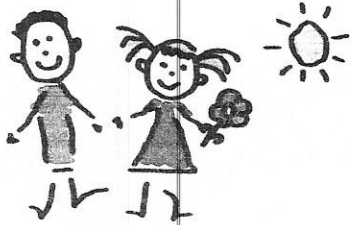
PERSON(S) NOT AUTHORIZED TO PICK UP YOUR CHILD		
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

**CUSTODY AGREEMENT:**       YES       NO

IF YES, SUPPLY A COPY OF THE CUSTODY ORDER TO THE FACILITY MANAGER/LICENSEE

ALTERNATE PERSON(S) TO CALL AND PICK UP CHILD IN CASE OF EMERGENCY		
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

CHILD'S IMMUNIZATION STATUS (Please record dates [year/month/day] or attach copy of immunization)					
IS YOUR CHILD IMMUNIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO					
DIPHTHERIA	PERTUSSIS	TETANUS	POLIO	MMR (Measles/Mumps/Rubella)	HIB
1.	1.	1.	1.	1.	1.
2.	2.	2.	2.	2.	2.
3.	3.	3.	3.		
4.	4.	4.	4.		
5.	5.	5.	5.		
COMMENTS:					



# Somewhere to "Grow" Montessori Preschool and Kindergarten

## HEALTH INFORMATION

[Please attach a separate sheet, if necessary]

REGULAR MEDICATION(S) AND REASONS FOR [PLEASE LIST]:

ALLERGIES AND TREATMENT OF [PLEASE LIST]:

INJURY(S), ILLNESS(ES) OR OPERATIONS YOUR CHILD HAS HAD AND INCLUDE DATE(S):

- a) Please describe any concerns/issues regarding your child's health (seizures, asthma, vision, hearing, etc.)
- b) Please describe any concerns you may have regarding your child's development [i.e., behaviour, vision, hearing, speech, language, mobility, etc.]:
- c) Describe any specific care instruction regarding a) and/or b):

OTHER HEALTH CARE PROFESSIONALS INVOLVED IN YOUR CHILD'S LIFE, E.G., OCCUPATIONAL THERAPIST/PHYSICAL THERAPIST:

## GROUP EXPERIENCES

WHAT IS/ARE YOUR CHILD'S FAVOURITE TOY(S)/ACTIVITIES:

HAS YOUR CHILD HAD PREVIOUS PLAY GROUP EXPERIENCE?  YES  NO

IF YES, HOW DID HE/SHE ADAPT?

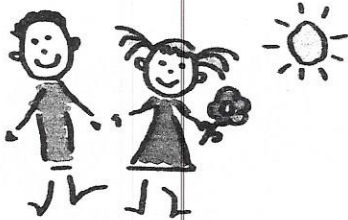
HOW DOES YOUR CHILD BEHAVE TOWARD OTHER CHILDREN [E.G., SEEKS OTHERS OUT, FEELS SHY]:

## EMOTIONAL

HOW DOES YOUR CHILD REACT WHEN LEFT WITH UNFAMILIAR PEOPLE AND/OR IN UNFAMILIAR SITUATIONS?

DOES YOUR CHILD HAVE ANY PARTICULAR FEARS? PLEASE DESCRIBE:

WHAT SUGGESTIONS DO YOU HAVE THAT WOULD HELP STAFF MAKE YOUR CHILD'S TRANSITION INTO THIS PROGRAM EASIER?



# Somewhere to "Grow" Montessori Preschool and Kindergarten

## FAMILY AND GENERAL HOUSEHOLD INFORMATION

PLEASE LIST THE NAMES OF THE SIGNIFICANT PEOPLE IN YOUR CHILD'S LIFE [E.G., SIBLINGS, GRANDPARENTS, ETC.]:

PLEASE DESCRIBE THE GUIDANCE AND DISCIPLINE METHODS USED AT HOME:

PRIMARY LANGUAGE SPOKEN IN THE HOME:

OTHER LANGUAGES:

NAME OF ENGLISH SPEAKING PERSON [IF NEEDED]:

PHONE:

## ANY OTHER COMMENTS

## SIGNATURE OF PARENT OR GUARDIAN PROVIDING INFORMATION

SIGNATURE:

PRINT NAME:

DATE:

NOTE: This information may be reviewed by Fraser Health Authority Licensing staff as per legislation.

## FACILITY USE ONLY

*Staff person reviewing family's documents:*

SIGNATURE:

PRINT NAME:

DATE:

CHILD'S WITHDRAWAL DATE:

REASON FOR WITHDRAWAL:



# Somewhere to "Grow" Montessori Preschool and Kindergarten

## EMERGENCY CONSENT CARD

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

ADDRESS: \_\_\_\_\_  
CHILD LIVES WITH: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

FATHER NAME: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

CHILD'S M.D.: \_\_\_\_\_ PHONE: \_\_\_\_\_

1) ALLERGIES \_\_\_\_\_

2) MEDICATIONS: \_\_\_\_\_

CHILD'S DENTIST: \_\_\_\_\_ PHONE: \_\_\_\_\_

CARE CARD # \_\_\_\_\_ DATE EFFECTIVE: \_\_\_\_\_

## CONSENT FORM

- 1) It is the policy of this centre 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 take the child to the nearest emergency service.
- 2) Please sign the consent below so that we can take appropriate action on behalf of your child. Return the signed consent to the centre immediately. We will take this consent with us to the emergency centre.
- 3) I hereby give consent for my child \_\_\_\_\_ when ill to be taken to the nearest emergency centre by the Care Facility Staff when I cannot be contacted.
- 4) I hereby give consent for my child \_\_\_\_\_ to receive medical treatment.

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

PICTURE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE

Personal information contained on this form is collected under the Community Care Facility Act and will be used only for the purpose indicated.