MOTHER OF CARMEL CHILDCARE CENTRE
2599 MAJOR MACKENZIE DRIVE, MAPLE, ONTARIO L6A 1C6
Tel: 905-303-1000 Fax: 905-303-0977
E-mail: smcdaycare@rogers.com Website: www.motherofcarmelchildcare.com

APPLICATION FOR ENROLLMENT

CHILD NAME:_____ DATE OF BIRTH:_____
HOME ADDRESS:_____ HOME PHONE #:_____
LANGUAGES SPOKEN:_____

MOTHER'S NAME:_____ CELL PHONE #:_____
MOTHER'S PROFESSION:_____ E-MAIL: _____
HOME ADDRESS:_____ HOME PHONE #: _____
WORK ADDRESS:_____ WORK PHONE #:_____

FATHER'S NAME:_____ CELL PHONE #:_____
FATHER'S PROFESSION:_____ E-MAIL: _____
HOME ADDRESS:_____ HOME PHONE #: _____
WORK ADDRESS:_____ WORK PHONE #:_____

PERSON TO BE CONTACTED, IF PARENTS CANNOT BE REACHED IN CASE OF EMERGENCY DURING THE HOURS OF CARE

NAME:_____ RELATIONSHIP TO CHILD:_____

ADDRESS:_____

HOME PHONE #: (_____) _____ WORK PHONE # (_____) _____

CELL PHONE #: (_____) _____

NAME OF PERSONS TO WHOM THE CHILD MAY BE RELEASED

NAME:_____ TELEPHONE #:(_____) _____

MEDICAL HISTORY

CHILD'S FAMILY PHYSICIAN: _____ OFFICE PHONE #:_____

ADDRESS:_____

CHILD'S ONTARIO HEALTH CARD NUMBER: _____

CHILD'S PREVIOUS HISTORY OF COMMUNICABLE DISEASES:

_____ DATES:_____
_____ DATES:_____

OTHER INFORMATION:_____
_____

SPECIAL MEDICAL CONDITIONS:_____

SYMPTOMS OF CHILD'S ILL HEALTH (INDICATE CHILD'S USUAL REACTIONS TO ILLNESS, EX: HIGH TEMPERATURE, PALE, VOMITING, IRRITABILITY, ETC.) _____

CHILD'S ALLERGIES: _____

_____

RECORD OF IMMUNIZATION

(IF THE CHILD HAS NOT BEEN IMMUNIZED, A PARENT OF THE CHILD MUST PROVIDE A WRITTEN STATEMENT THAT IMMUNIZATION CONFLICTS WITH THE SINCERELY HELD CONVICTION OF A PARENTS' RELIGION OF CONSCIENCE OR A LEGALLY QUALIFIED PRACTITIONER MUST GIVE MEDICAL REASONS IN WRITING AS TO WHY THE CHILD SHOULD NOT BE IMMUNIZED)

CHILD'S NAME:_____ WEIGHT:_____ HEIGHT:_____

DIPHTHERIA	DATE:_____	DATE OF BOOSTER:_____
PERTUSSIA	DATE:_____	DATE OF BOOSTER:_____
MUMPS	DATE:_____	DATE OF BOOSTER:_____
MEASLES	DATE:_____	DATE OF BOOSTER:_____
TUBERCULIN TEST	DATE:_____	DATE OF BOOSTER:_____
WHOPPING COUGH	DATE:_____	DATE OF BOOSTER:_____
OTHERS (SPECIFY)	DATE:_____	DATE OF BOOSTER:_____

MEDICAL TREATMENT

DRUG OR MEDICATION TO BE ADMINISTERED DURING THE HOURS THE CHILD IS RECEIVING CARE.

(Written and signed instructions must be provided by a parent of the child)

SPECIAL REQUIREMENT FOR DIET, REST OR EXERCISE (WRITEN AND SIGNED INSTRUCTIONS MUST BE PROVIDED BY A PARENT OF THE CHILD): _____

_____

_____

IMPORTANT NOTE: PLEASE COMMENT ON YOUR CHILD'S DEVELOPMENT, GIVING INFORMATION THAT WILL BE USEFUL IN THE PROVISION OF CARE (EX: CHILD'S HABITS, FAVORITES, ROUTINES, FEARS, ETC.) _____

_____

_____

ADDITIONAL INFORMATION:_____

_____

_____

IS THIS CHILD UNDER ANY FORM OF TREATMENT FOR ILLNESS OR INJURY? _____

IF YES, PLEASE EXPLAIN:_____

_____

WILL THIS PROBLEM INTERFERE WITH HIS/HER PARTICIPATION IN ACTIVITIES AT DAY CARE?

_____

PARENT SIGNATURES

MOTHER'S SIGNATURE: _____	DATE:_____
FATHER'S SIGNATURE: _____	DATE:_____
DATE OF ADMISSION: _____	DATE OF DISCHARGE:_____
NOTED BY: _____	DATE:_____

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PARENTAL POLICY AGREEMENT

I, _____, hereby acknowledge that I have read and understood the policies outlined in the included Parents Manual. I agree to comply with the policies outlined herein.

Failure to conform to any of these policies could result in the termination of my child's enrollment at Mother of Carmel Childcare Centre.

Signature of Parent of Guardian:_____ Date:_____

Noted By:_____

Signature of Director:_____ Date:_____

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IMPORTANT MEDICAL INFORMATION REGARDING YOUR CHILD'S CARE

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

HEALTH CARD NUMBER: _____

SURNAME: _____ **INITIALS:**_____

MEDICAL RELEASE

IF AT ANY TIME DUE TO CIRCUMSTANCES SUCH AS ACCIDENT, SUDDEN ILLNESS OR EMERGENCY, MEDICAL TREATMENT IS REQUIRED, THIS MAY BE GIVEN, INCLUDING ANESTHETIC IF NECESSARY, BY A PRIVATE PHYSICIAN OR HOSPITAL. I ALSO CONSENT TO EMERGENCY TRANSPORTATION IF NECESSARY.

PARENTS SIGNATURE:_____ DATE:_____

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CONSENT FORM

PERMISSION TO RECEIVE EMERGENCY MEDICAL CARE

NAME OF THE CHILD:_____

HEALTH CARD NUMBER:_____

I HEREBY GRANT PERMISSION FOR THE OPERATOR, OR DESIGNATE, OF THIS CHILDCARE CENTRE TO TAKE WHATEVER STEPS NECESSARY TO OBTAIN EMERGENCY MEDICAL CARE FOR MY CHILD IF NECESSARY.

THESE STEPS INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING

1. ATTEMPT TO CONTACT A PARENT OR GUARDIAN
2. ATTEMPT TO CONTACT THE CHILD'S PHYSICIAN
3. ATTEMPT TO CONTACT EMERGENCY CONTACT PERSON

IF WE CANNOT CONTACT PARENT/GUARDIAN, YOUR CHILD'S PHYSICIAN OR AN EMERGENCY CONTACT PERSON, WE WILL DO ANY OR ALL OF THE FOLLOWING

1. CALL ANOTHER PHYSICIAN
2. CALL AN AMBULANCE
3. HAVE THE CHILD TAKEN TO THE EMERGENCY DEPARTMENT OF THE HOSPITAL, IN THE COMPANY OF A STAFF MEMBER

NAME OF FAMILY DOCTOR:_____

TELEPHONE NUMBER:_____

ANY EXPENSES INCURRED UNDER CIRCUMSTANCE LISTED ABOVE WILL BE BORN BY THE CHILD'S FAMILY.

THE CENTRE WILL NOT BE RESPONSIBLE FOR ANY INCIDENT THAT MAY OCCUR AS A RESULT OF FALE INFORMATION GIVEN AT THE TIME OF ENROLLMENT.

ACTIVITIES OFF PREMISES

FROM TIME TO TIME THE CHILDREN WILL BE TAKEN ON WALKS IN THE NEIGHBOURHOOD AND/OR TO THE LOCAL PARK

PARENT / GUARDIAN SIGNATURE:_____ DATE:_____

WITNESS:_____ DATE:_____