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BEFORE AND AFTER SCHOOL REGISTRATION.

NAME OF THE CHILD: _____

CHILD'S STARTING DATE:
_____/_____/_____
YY MM DD

SEX:
M ____ F ____

DATE OF BIRTH:
_____/_____/_____
YY MM DD

GRADE IN SEPTEMBER:

TEACHER:

DIVISION:

Address: _____

Postal code: _____ Phone: _____

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

Child's first language: _____ Other languages: _____

BSC	7:30-9:00				
ASC	3:00/6:00				

Parent(s) / guardian(s):

Name: _____ Phone #: _____ Cell: _____

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

Name: _____ Phone #: _____ Cell: _____

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

If appropriate, list an English speaking contact:

Name: _____ Phone: _____

Has the child previously attended daycare?

YES NO Comments: _____

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	Phone:
_____	_____	_____
_____	_____	_____

Does your child have:

revised April, 2010

A medical or behavioural condition/concern? For example, does your child wanders, leaves the group, frequent nose bleeds, anger, etc.
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:

This health information may be made available to the staff of Vancouver Coastal Health. Vancouver Coastal Health may ask you to complete additional forms if you answered yes to any of the above.

Custody agreement	YES	NO	Provided to the facility	YES	NO	N/A
Immunization records provided	YES	NO				
<u>Information provided by:</u>						
Date:	___/___/___	_____	_____	_____	_____	_____
	YY	MM	DD	Name	Signature	
<u>Information received by:</u>						
Date:	___/___/___	_____	_____	_____	_____	_____
	YY	MM	DD	Name	Signature	

IMPORTANT: PJ Kids Club is a non profit organization, and we need parent volunteers that can help with the operations of the center. In which areas of your expertise would be available to help us? Computers, Advertising, Taking Decisions, Accounting, or simply be willing to share your ideas to serve our families better!

Thank you for taking the time to fill this question!

CHILD CARE 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 _____

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

Provided by VCH - Community Care Facilities Licensing

Please attach
child's photo
to this form.