

CHILD'S LAST NAME	FIRST NAME	DATE OF BIRTH	ALBERTA HEALTH CARD

**CHECK APPLICABLE INFORMATION**

Court Order  Separation Agreement  Not Applicable

Invalid without supporting documentation      Effective Date: \_\_\_\_\_ Type of custody: Sole\* / Joint\*  
(MM/DD/YY)

**Would you like both parents/guardians to be able to access billing information? Yes \_\_\_\_\_ No \_\_\_\_\_**

**Parent/Guardian Information**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

**Home Information**

**Home Information**

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

City: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Postal Code \_\_\_\_\_

Phone Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Alternate Phone/Cell: \_\_\_\_\_

Alternate Phone/Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_ (For Invoicing)

**Workplace Information**

**Workplace Information**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**EMERGENCY CONTACTS TO WHOM THE CHILD MAY BE RELEASED:**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

Phone Numbers: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

I certify that all the information given on this form is correct and accurate to the best of my knowledge. I will notify both the day home provider and agency staff if any or all of the information changes.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Child's Name:** \_\_\_\_\_

1. What language(s) are spoken in the home? \_\_\_\_\_

2. What type of childcare has your child experienced?  
\_\_\_\_\_

3. What specific activities do you think would benefit your child in day home?  
\_\_\_\_\_

4. Are there any holidays/activities that you do not want your child to participate in?  
\_\_\_\_\_

5. Describe your child's personality \_\_\_\_\_

6. What is your approach to child guidance? \_\_\_\_\_

7. Is your child potty trained? \_\_\_\_\_

8. Does your child have any fears? \_\_\_\_\_

9. What is your child's napping/quiet time routine? \_\_\_\_\_

10. Does your child have a security object? \_\_\_\_\_

11. What is your parenting style (co-sleeping, baby wearing, etc.)?  
\_\_\_\_\_

12. Does your child have a security object? \_\_\_\_\_

13. Has there been any occurrence in the past, which may have caused emotional upset to your child?  
\_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Child's Name:** \_\_\_\_\_

**Child's Physician**

Physician's Name: \_\_\_\_\_

Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Does your child require?**

INHALER: Yes \_\_\_\_\_ No \_\_\_\_\_

EIPEN: Yes \_\_\_\_\_ No \_\_\_\_\_

Other: \_\_\_\_\_ (please specify) \_\_\_\_\_

ALLERGY	SYMPTOMS	TREATMENT
_____	_____	_____
_____	_____	_____
_____	_____	_____

PRESENT MEDICAL CONDITION(S)	SYMPTOMS	TREATMENT
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Nutrition Information:**

Dietary Concerns/Special Diet: \_\_\_\_\_

Food Likes: \_\_\_\_\_

Food Dislikes: \_\_\_\_\_

Are there any foods you DO NOT want your child to eat? \_\_\_\_\_

**Our agency requires an up-to-date immunization record and an updated copy EVERY TIME your child receives a new set of immunizations shots.**

I certify that all the information given on this form is correct and accurate to the best of my knowledge. I will notify both the day home provider and the agency staff if any or all of the information changes.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**EMERGENCY MEDICAL CONSENT**

Your provider is responsible for planning and carrying out a program with care and concern for the physical safety and well being of each child in their care. However, in the case of illness or injury to my child, I agree that my provider (or back up provider) should immediately proceed in obtaining medical treatment for my child as is deemed necessary. I authorize the administration of any medical procedures deemed necessary by my doctor or, if unavailable, by any other physician selected by the day home provider or the day home coordinator. I understand that I cannot hold my provider or the Wee R Kids Family Day Homes agency responsible for any injury or illness and will assume responsibility for any expense incurred with the emergency treatment.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

**ACTIVITIES CONSENT**

I hereby give consent for my child, \_\_\_\_\_ to participate in daily activities with the day home provider. These activities may include walking, playing in the park, and other activities that are safe, reasonable, and appropriate for the occasion. These activities will be planned and carried out for the benefit of the children, and not be for the convenience of the provider. I understand that when transportation is required, an additional permission form will be presented to me prior to the excursion for my consent.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

**PHOTOGRAPH CONSENT**

I give permission for my child, \_\_\_\_\_ to be photographed in the day home by the provider and by the day home visitor/coordinator. I understand that these photographs will be used only in the day home, and in the office for portfolio purposes. These photographs will not be used online, social media, advertising or promotion.

I certify that all the information given on this form is correct and accurate to the best of my knowledge. I will notify both the day home provider and the agency staff if any or all of the information changes.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

<p><b>Internal Use Only</b></p> <p>Start Date: _____</p> <p>Updated: _____</p> <p>Updated: _____</p>	<p>Withdrawal Date: _____</p> <p>Reason for withdrawal: _____</p>
--	---