

Registration Date \_\_\_\_\_ Start Date \_\_\_\_\_

Child's Name		First	Last	Male <input type="checkbox"/> Female <input type="checkbox"/>	
Date of Birth		Medicare #		Expiry Date	
Address		Street	Apt #	City/Town	Prov Postal Code
Parent/Guardian Name			Email Address		Home Telephone Number
Address		Street	Apt #	City/Town	Prov Postal Code
(if different from child's)					
Place of Work			Work Telephone Number		Cell Telephone Number
Parent/Guardian Name			Email Address		Home Telephone Number
Address		Street	Apt #	City/Town	Prov Postal Code
(if different from child's)					
Place of Work			Work Telephone Number		Cell Telephone Number
Child's Living Arrangement					
Other than you, who has permission to pick up your child?					
Name	Relationship	Address		Daytime Telephone Number	

If changing pick up arrangements parents must inform the facility prior to the child being picked up.

Is there anyone who does not have permission to pick up your child?
Name _____
Name _____
Name _____

Appropriate paperwork such as custody papers must be attached if a parent is not permitted to have contact with the child. Please discuss with the operator/administrator.

Two emergency contacts (other than parents/guardians)			
Must be able to respond within one hour if parent(s)/guardian(s) cannot be reached			
Name	Relationship	Address	Daytime Telephone Number

#### Child's health record

<b>ALLERGY ALERT:</b> Please list any serious allergies   
Are any of the above allergies severe enough to require EpiPen, medications, or emergency treatment? Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please complete an Allergy Management and Emergency Plan available from the operator. Please list any food, medication or contact allergies (non-life threatening)  
Does your child require any essential routine services on a regular basis as part of a daily routine such as, catheterization, special hygiene procedures, on-going administration of medication, or ongoing observation of certain health conditions, such as diabetes, to determine when intervention is needed? Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please complete an Essential Routine Services and Emergency Plan available from the operator. Name of Medical Practitioner _____ Telephone Number _____ Address _____

<b>Medical History:</b> Please indicate if your child has <b>had</b> any of the following:					
	Yes	No		Yes	No
Measles			Rubella		
Mumps			Chicken Pox		
Meningitis			Pertussis (Whooping Cough)		
<b>Health Status:</b> Indicate if your child <b>has</b> any of the following:					
	Yes	No		Yes	No
Asthma			Diabetes		
Eczema/Psoriasis			Epilepsy/Seizures		
Other:			Other:		
<b>Ongoing Medical Treatment:</b> Please indicate any ongoing medical treatment your child may need (you will be required to complete an Administration of Medication form)					
Name of medication			Dosage		
Condition being treated					
Name of medication			Dosage		
Condition being treated					
<b>Immunizations:</b> In accordance with subsection 12(2) of the <i>Reporting and Diseases Regulation - Public Health Act</i> , proof of immunization must be provided for each child attending an early learning and childcare facility for the following:					
diphtheria	rubella	mumps			
tetanus	varicella	measles			
polio	meningococcal disease	Haemophilus influenza type B			
pertussis	pneumococcal disease				
<b>Where proof is not provided you must have the following waivers:</b> <ul style="list-style-type: none"> <li>- a medical exemption, on a form provided by the Minister of Health, that is signed by a medical practitioner or nurse practitioner, or</li> <li>- a written statement, on a form provided by the Minister of Health, signed by the parent or legal guardian of his or her objections to the immunizations required by the Minister.</li> </ul>					
<b>Note:</b> Public Health will periodically review child files to ensure immunizations are complete or waivers are present.					
Are there any activities in which your child cannot medically participate?					
Please list any dietary restrictions (including those for medical, cultural, religious reasons):					

Please advise the operator/administrator immediately of any changes to your child's health.

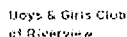
### Preschool/childcare history

Has your child attended preschool/childcare before?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
If yes, for how long?	6 months <input type="checkbox"/>	1 year <input type="checkbox"/>	2 years <input type="checkbox"/>	more than 2 years <input type="checkbox"/>
If yes, please describe your child's experience:				

### Child development

<b>Self Help: Does your child need help with the following? If yes, in what way?</b>	
Dressing/Undressing:	
Eating:	
Toileting:	
Handwashing/Toothbrushing:	
Other: (ie: gross and/or fine motor skills)	
Are there any hints/suggestions that will make your child's transition to the facility a positive one?	
<b>Tell us a few things about your child</b>	
What does your child like to do? (i.e.: look at books, listen to music, play with other children, play outdoors/indoors, toys, climb/run/jump, paint, computer, imaginative play/dress-up)	
Is there anything else you would like to share with us about your child?	
Parent/Guardian Signature	Date
Parent/Guardian Signature	Date

Information on this form is to be verified for accuracy annually.  
Please immediately advise the operator/administrator of any changes.



**School:** \_\_\_\_\_

<b>Childs Basic Information</b>			
Childs Surname: (Please Print)		Childs First:	Childs Middle:
Allergies:		Date of Birth: (mm/dd/yyyy)	
Primary Address:			
City/Town	Province	Postal Code	Medicare #
<b>Mother/Female Guardian</b>			
Surname: (Please Print)	First:		Middle:
Home Phone:	Work:	Cell:	
Primary Address:			
City/Town:	Province:	Postal Code:	Email:
<b>Father/Male Guardian</b>			
Surname: (Please Print)	First:		Middle:
Home Phone:	Work:	Cell:	
Primary Address:			
City/Town:	Province:	Postal Code:	Email:
<b>Emergency Contacts</b>			
Surname: (Please Print)	First:		Relationship:
Home Phone:	Work:	Cell:	

Surname: (Please Print)	First:	Relationship:
Home Phone:	Work:	Cell:

**Who is allowed to pick up your child?** (Pick up list: only those people listed as emergency contacts and listed here will be allowed to pick up your child. Please print neatly and list parents names as well.)

[illegible]



Boys & Girls Club  
of Riverview

### Consent for Transportation on Outings

☐ Yes  
☐ No

I authorize the operator / administrator / staff of The Boys & Girls Club of Riverview to take my (our) child on outings, excursions and activities away from the facility, in a vehicle providing the driver and said vehicle are properly insured for the carrying of passengers.

I (we) understand that I (we) will receive advance notice of each planned outing, excursion, or activity away from the premises.

### Consent for Information Gathering

☐ Yes  
☐ No

I understand that, as a non-profit, The Boys & Girls Club of Riverview applies for program grant funding for their many programs. A requirement of these grants may be to provide outcome measurements and data of how the funds are used. I give consent for them to conduct surveys with my child, to ask them their opinions/feelings about the program they have taken part in. Names or other identifying information will NEVER be collected or shared.

### Consent for Indirect Supervision

☐ Yes  
☐ No

The children in the After School Adventure Camp program are supervised at all times. However, the supervision of school aged children may not always be direct. In an effort to promote greater independence, indirect supervision of school aged children at The Boys & Girls Club of Riverview After School Adventure Camp is, at times, permitted in order to allow children to move freely from one program to the next within school age daycare classrooms, hallways for access to book bags and lunches, washroom trips and to go from one room to another.

While on outings, during outdoor play at the club or when children are in shared spaces such as the washrooms that could be used by the public within the Coverdale Center, direct supervision is always provided as required by the Department of Education and Early Childhood Development.

I give consent for The Boys & Girls Club of Riverview to, at times, use indirect supervision as described above.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

Please complete this consent form and return to the facility

Name of ELC facility: \_\_\_\_\_

<b>Child's Name</b>	<b>Date</b>
<b>Consent for emergency care and transportation</b>	
<p>If at any time medical treatment is necessary, due to circumstances such as an injury or sudden illness, I authorize the early learning and childcare staff to take whatever emergency measures are necessary for the protection of my child while in their care.</p> <p>I understand this may involve applying first aid, contacting a medical practitioner, carrying out the instructions given, and/or transporting my child to a hospital, including the possible use of an emergency vehicle.</p> <p>I understand that this may be necessary prior to contacting me and that any expense incurred for such treatment, including emergency transportation is my responsibility.</p>	
<b>Parent/Guardian Signature</b>	<b>Date</b>
<b>Parent/Guardian Signature</b>	<b>Date</b>
<b>PLEASE INDICATE YOUR CONSENT AND SIGN AT THE BOTTOM OF THE FORM</b>	
<b>Administration of acetaminophen consent</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>I give consent for acetaminophen to be administered to my child <b>providing I have been contacted first</b> to provide oral consent and to indicate the dosage.</p> <p>On picking up my child at the facility I understand I will be asked to sign a written acknowledgement that acetaminophen was administered with my consent.</p> <p>I also understand that the acetaminophen is to relieve my child of minor discomfort or to help lower a fever while I am on my way to pick them up (within one hour).</p> <p><b>Reason:</b> Fever above _____ Celsius      Body ache _____</p> <p>Other _____</p>
<b>Consent for my child to be taken on walking outings/excursions off the premises</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>As a part of the day, walking trips may be taken off the premises, within the neighbourhood. Consent will provide more flexibility and allow for more spontaneity in the planning.</p> <p>Consent forms for any motor transportation trips will be separate and for each outing.</p> <p>I give permission for my child to be able to participate in the walking trips off the premises.</p>

**Consent for videographing and photographs**

- ☐ Yes  
☐ No

I give consent for my child to be videographed or photographed participating in the facility for the following reasons:

- ☐ Yes ☐ No Social Media such as Facebook  
☐ Yes ☐ No Facility's website  
☐ Yes ☐ No Publication  
☐ Yes ☐ No Illustrate child's learning within the facility

**Consent for child to walk/bicycle to and from school unattended (school-age children only)**

- ☐ Yes  
☐ No  
☒ N/A

I give consent for my school-aged child to travel to and from school unsupervised. If my child does not arrive at the facility within the pre-determined time period, the missing child or other procedures will be initiated to find him/her. I will advise the facility when my child is absent.

**Consent for transportation to and from school (school-age children only)**

- ☐ Yes  
☐ No  
☐ N/A

I authorize the operator to transport my child to and from school by the authorized facility vehicle or by walking. Where applicable, appropriate seat restraints are used.

**Consent for bathing**

- ☐ Yes  
☐ No  
☒ N/A

I give permission to bathe my child if this becomes necessary due to the child becoming dirty while at the facility; either through play (paint, mud, sand, etc.) or because of a toilet accident.

Also applies to overnight care where bathing is part of the night time routine.

To ensure the health and safety of children who may require bathing, children must be:

- bathed individually and supervised according to developmental needs;
- never left unattended; and
- bathed as quickly as possible and dressed appropriately.

Staff will supervise or bathe the child upon instructions of the parent according to their age, adhering to safety standards.

Bathtubs will be equipped with a nonskid mat or surface.

- ☐ Yes  
☐ No

I have read, understand and been provided a copy of the facility's parent/guardian handbook.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date



**This form is valid for no more than 12 months.  
One form must be completed for each medication.**

Child's Name		First	Last	Date of Birth
Medication		Dosage		How is medication to be given
Medication is to be administered at the following times. (If the medication is to be administered on an "as needed" basis, the written instructions must clearly indicate the situations under which the medication should be given. This could include the physical symptoms that must be present, the behaviour the child must be exhibiting or the child's temperature. Simply indicating "as needed" or "as required" is not sufficient.)				
For the following period of time				
Special Instructions (e.g. give with food)			Storage Instructions (e.g. refrigerate)	
Reason for medication				
<b>POSSIBLE SIDE EFFECTS TO WATCH FOR WITH THIS MEDICATION – parents are to be notified immediately of any of these side effects</b>				
<b>I give permission for the administration of the above medication, according to the instructions provided, to the child listed above.</b>				
Date of consent		Signature of parent/guardian		

**FOR STAFF REVIEW PRIOR TO ADMINISTERING MEDICATION:**

<b>Is the medication consent form complete?</b>
<b>Is the original prescription label on the medication container or is the medication in the original manufacturer's container?</b>
<b>Is the full name of the child on the container?</b>
<b>Is the prescription or over-the counter medication current and not expired?</b>
<b>Is the dose, name of medication, and frequency of administration on label consistent with the instructions above?</b>

The section below must be completed and each administration of medication must be documented when it is given.

[illegible]

## **PARENT'S POLICY HANDBOOK CONFIRMATION**

We require a confirmation from parents of all children enrolled in our programs that they have, in fact, read and understand the enclosed Parent's Policy Handbook. Please read this manual. Ask any questions you may have but once completed, please sign below and return this form to the office for inclusion in your child's profile. This is a required document.

**I have read and understand all policies listed in the Parent's Policy Handbook. I understand the conditions to which the programs described herein operate and what my requirements to its continued success will be.**

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

**Parent's Name:** \_\_\_\_\_

**Parent's Signature:** \_\_\_\_\_

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

Regards –

Lynda Carey  
Executive Director

