

Registration Form

Revised August 2018

General Information

Child's Name _____
First Name Middle Name Last Name

Sex (circle) M F Weight _____ Height _____

Date of Birth _____ / _____ / _____ School _____
Year Month Day

Exceptional Needs / Special Social Needs & Subsidy

Subsidy Number _____ Subsidy Start _____ Date Subsidy Expiry Date _____
(YY / MM / DD) (YY / MM / DD)

Restrictions _____

Family Plan (circle) Applicable N/A File by _____

Divorced / Separated

1. Is this child permitted access by the other parent? NO YES

2. Is there a restraining order/custody order in place? NO YES

If YES, please provide us with a copy so that it may be enforced if necessary.

I have spoken with the Site Manager regarding this issue and acknowledge discussion/receipt of copy of Child Day Care Protocol Understanding Custody Arrangements and Court Orders Issued by the Criminal or Family Law Courts.

Date _____ / _____ / _____ Signature _____
Year Month Day

MACCPF Programs & Sites

Site Name (circle):

Archwood Centre 24/7 Dr. D.W. Penner Glenwood Hastings Lavallee West MAG Rene DeLeurme
 Salvation Army Victor Wyatt

Program (circle):

Infant Preschool Junior Kindergarten Nursery Kinder AM / PM School Age Grade _____ Room _____

Fee Payer (circle) Mother Father Other _____

Subsidy (circle) Ineligible Applied Approved: Copy Provided

Start Date _____ Withdrawal Date _____
(YY / MM / DD) (YY / MM / DD)

Staff Use – Deposit & Registration Fee

\$100 Refundable Security Deposit Rec'd by _____ Chq # _____ Date _____

\$25 Non-Refundable Reg. Fee Rec'd by _____ Chq # _____ Date _____

Contacts (Parent / Guardian)

Contact Name _____
First Name Last Name

Address _____
Street City Province Postal Code

Home Phone _____ Cell Phone _____

Work/School Phone _____ Pager _____

Email _____

Occupation _____ Employer/School _____

Employer /School Address _____
Street City Province Postal Code

Days & Hours Worked _____

Relationship to Child _____ Primary Caregiver (circle) YES NO

Circle all relevant Emergency Contact Lives With Pick Up Authority Restraining Order

Contacts (Parent / Guardian)

Contact Name _____
First Name Last Name

Address _____
Street City Province Postal Code

Home Phone _____ Cell Phone _____

Work/School Phone _____ Pager _____

Email _____

Occupation _____ Employer/School _____

Employer /School Address _____
Street City Province Postal Code

Days & Hours Worked _____

Relationship to Child _____ Primary Caregiver (circle) YES NO

Circle all relevant Emergency Contact Lives With Pick Up Authority Restraining Order

Other Contact

Contact Name _____
First Name Last Name

Address _____
Street City Province Postal Code

Home Phone _____ Cell Phone _____

Work Phone _____ Pager _____

Email _____

Occupation _____ Employer/School _____

Employer /School Address _____
Street City Province Postal Code

Days & Hours Worked _____

Relationship to Child _____ Primary Caregiver (circle) YES NO

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Contact Name _____
First Name Last Name

Address _____
Street City Province Postal Code

Home Phone _____ Cell Phone _____

Work Phone _____ Pager _____

Email _____

Occupation _____ Employer/School _____

Employer /School Address _____
Street City Province Postal Code

Days & Hours Worked _____

Relationship to Child _____ Primary Caregiver (circle) YES NO

Circle all relevant Emergency Contact Lives With Pick Up Authority Restraining Order

Siblings

Sibling Name _____
First Name Middle Name Last Name

Sibling Name _____
First Name Middle Name Last Name

Sibling Name _____
First Name Middle Name Last Name

Health & Medical Information

MHSC No. _____ Individual No. _____ Health Plan No. _____

Allergies / Medical Conditions _____

Diagnosis Agency _____ Date of Diagnosis _____ Agency Involved (circle) YES NO
(YY / MM / DD)

Exceptional Needs Diagnosis _____

Tested for Senses (circle) YES NO Required Treatment _____

Treatment Details _____

Other Information _____

Family Physician

Physician Name _____
First Name Middle Name Last Name

Agency/clinic Name _____

Address _____
Street City Province Postal Code

Work Phone _____

Fax _____ Email _____

Comment _____

Growth & Development

Eating Habits _____

Food Dislikes _____

Languages Spoken _____

Dominant Hand _____

Nap Information _____

Dressing Help Info _____

Toilet Help Info _____

Favorite Activity _____

Playing Habits _____

Playing Difficulties _____

Friends _____

Previous Care _____

Current Discipline _____

Other Information _____

The following release forms refer to my child _____ Site: _____

Illness / Emergency Release

I hereby give my consent to have my child receive any required medical care at a Winnipeg Hospital. I am aware that an ambulance will be called and my child will be taken to the nearest hospital (at the ambulance driver's discretion). I am also aware that my child/ren will be accompanied to the hospital by an authorized employee of Morrow Avenue Child Care Programs, Inc.

Date _____ Signature _____

Medicine

I will make every attempt to administer medication to my child at home. In the event that the medication needs to be administered during Facility hours, the following conditions will be respected: The medicine will be prescribed by a medical doctor, will be provided to a staff member in the original container with a legible prescription indicating the date, doctor's name, dosage and instructions. I will sign a further, more detailed medicine consent form at that time.

Date _____ Signature _____

Sunscreen

I hereby authorize the Centre to apply Sunscreen SPF 30+ on my child during the season when children are at risk from the sun (May 1st – September 1st). I am aware that the Centre will post signs notifying me of this action in advance of the season.

Date _____ Signature _____

Insect Repellent

I hereby authorize the Centre to apply Skintastic by OFF as an insect repellent on my child during the season when children are at risk from insect bites. I am aware that the Centre will post signs notifying me of this action in advance of the season.

Date _____ Signature _____

Field Trips

I hereby give permission for my child to attend planned as well as spontaneous field trips with the centre. I understand that this includes excursions on foot or on public transportation. (i.e. Local parks/playgrounds; 7-11 stores; fire hall etc.). Parents will always be contacted by phone for verbal permission and this will be noted in the communication book. I am aware that I have a right to withdraw my child from attending an outing and if so, the Centre will make every attempt to offer alternate care at another MACCPF site.

Date _____ Signature _____

Supervision of School Age Children

All School Age Sites have an Indirect Supervision Policy that applies to the building in which they are located. Please see the Appendix to the Enhanced Safety Plan for your site or ask the Site Manager for a copy. I understand that as a means of recognizing the independence of Kindergarten and School Age Children, the staff do not accompany them to the washroom and/or other rooms within the building that houses the Centre.

Date _____ Signature _____

Photography / Video

I hereby give permission for my child to be photographed for display in the Centre ONLY. I am aware that I can refuse this request.

Date _____ Signature _____

Release of Information to the Parent Board

For the purpose of organizing events (parties, board meetings, etc.) I authorize the Centre to release my phone number to a delegate of the Board of Directors.

Date _____ Signature _____

Sharing of Information

In the interest of promoting optimum development of my child, I consent to the sharing of information, related to my child, between the Centre and _____ School.

Date _____ Signature _____

Practicum

I give permission for my child to be observed by students in fields relevant to the field of child care. These observations will be kept in confidence and used only as a means to fulfill their course requirements. These observations must be approved by the Centre.

Date _____ Signature _____

Withdrawal

I am aware that I must provide the Centre with two (2) weeks' notice before withdrawing my child. If I fail to do this, I will assume the responsibility of paying two (2) weeks of fees and I will forfeit my deposit.

Date _____ Signature _____

Electronic Communication

I authorize MACCPF to send me email communication regarding my parent account, up-to-date Centre information, news and events (invoices, newsletters, calendars, etc.).

My E-mail is _____.

Date _____ Signature _____

Policy Agreement

1. I understand that if I fail to meet with any or all conditions as set out in the Parent Policy and Hand Book, provide false or misleading information, or fail to pay the required family contribution to a child care facility. I can be disqualified from receiving any Manitoba Early Learning and Child Care subsidy and shall, upon request by the Government of Manitoba, be required to repay in whole or in part any subsidy paid on my behalf related to this or any previous Manitoba Child Care subsidy application.

Date _____ Signature _____

2. I have read and understand all of the policies outlined in the Parent Policy, Privacy Policy and Code of Conduct for Morrow Avenue Day Care Inc. o/a Morrow Avenue Child Care Programs for Families and do hereby agree to abide by all of the policies stated therein.

Date _____ Signature _____

Site _____ Staff Signature _____

Parent Education Verification (If Employed, see Employment Verification Form)

Parent Student Name _____ Start Date _____ End Date _____

Name of School or Training Programs _____

Type of Courses / Training Program _____

School / Training

Indicate the start and end time on each day the student regularly attends class.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM							
PM							

Additional Comments:

Authorization

Authorized signature of Educational Institute: _____

Date _____ Signature _____

Parent Employment Verification (If attending School/Training see Parent Education Verification form)

Employee Name _____ First Date Worked _____

Work Schedule

Indicate the start and end time on each day the employee regularly works.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM							
PM							

If the employee is not scheduled for regular hours of work each day, please attach a shift schedule.

Employer Contact Information

Company Name _____

Address _____ City / Town _____ Postal Code _____

Contact Name _____ Title _____

Phone Number _____ Signature _____

Additional Comments:

Please fill out the Emergency Cards below:

Emergency Card		Site:	Updated on:
Child's Name _____	_____	_____	_____
First Name	Middle Name	Last Name	(DD / MM / YY)
Mother's Name _____	Home Phone _____	Cell _____	
Address _____	Email _____		
Work/School _____	Work/School Phone _____	Ext. _____	
Work/School Address _____			
Father's Name _____	Home Phone _____	Cell _____	
Address _____	Email _____		
Work/School _____	Work/School Phone _____	Ext. _____	
Work/School Address _____			

Medical Information

Doctor/Clinic _____	Phone _____
MHSC# _____	Personal Identification # _____
Allergies _____	

Emergency Contacts

Name & Relationship to Child _____	Home Phone _____			
Cell Phone _____	Address _____			
Employer/School (& address) _____	Employer/School Phone _____			
Check all relevant:	Emergency Contact	Lives With	Pick Up Authority	Restraining Order

Emergency Contacts

Name & Relationship to Child _____	Home Phone _____			
Cell Phone _____	Address _____			
Employer/School (& address) _____	Employer/School Phone _____			
Check all relevant:	Emergency Contact	Lives With	Pick Up Authority	Restraining Order

Comments
