Ritchie Bros. Auctioneers Child Care Facility
ENROLLMENT FORM

CHILD'S NAME: _____

Program Desired:
___ **Multi-Age Infant – Toddlers**
___ **Multi-Age 3-5 Program**
___ **Multi-Age Over 5 Years**

Personal Information

CHILD'S DATE OF BIRTH:	GENDER:	STARTING DATE:
ADDRESS:		POSTAL CODE:
		PHONE: ( )

PARENT OR GUARDIAN:	PARENT OR GUARDIAN:
ADDRESS {IF DIFFERENT FROM ABOVE}	ADDRESS {IF DIFFERENT FROM ABOVE}
PHONE:	PHONE:
WORK ADDRESS/ALTERNATE LOCATION:	WORK ADDRESS/ALTERNATE LOCATION:
PHONE {INCLUDE LOCAL}:	PHONE {INCLUDE LOCAL}:
CELLULAR/PAGER:	CELLULAR/PAGER:
HOURS AT THIS LOCATION:	HOURS AT THIS LOCATION:

Emergency Health Information

CARE CARD NUMBER:			
FAMILY DOCTOR/CLINIC NAME:		FAMILY DENTIST/CLINIC NAME:	
ADDRESS:	PHONE:	ADDRESS:	PHONE:

Consent for Emergency Care

I authorize the staff at the child care centre to call a medical practitioner or ambulance in the case of accident or illness if my child(ren), if the parent cannot immediately be reached.

SIGNATURE OF PARENT/GUARDIAN:	DATE:
MANAGER OF FACILITY:	

Person(s) Authorized to pick up Chid

(other than parent/guardian listed above)

NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

Emotional
HOW DOES YOUR CHILD REACT WHEN LEFT WITH UNFAMILIAR PEOPLE AND/OR IN UNFAMILIAR SITUATIONS?
DOES YOUR CHILD HAVE ANY PARTICULAR FEARS? PLEASE DESCRIBE:
WHAT SUGGESTIONS DO YOU HAVE THAT WOULD HELP STAFF MAKE YOUR CHILD'S TRANSITION INTO THIS PRGRAM EASIER?

Family and General Household Information	
NAME OF ENGLISH SPEAKING PERSON {IF NEEDED}	PHONE:

Any Other Comments

Signature of Parent or Guardian Providing Information		
SIGNATURE:	PRINT NAME:	DATE:

NOTE: This information may be reviewed by Fraser Health Authority Licensing staff as per Legislation

Facility Use Only		
Staff person reviewing family's documents:		
SIGNATURE:	PRINT NAME:	DATE:
CHILD'S WITHDRAWAL DATE:	REASON FOR WITHDRAWAL:	

Eating and Nutrition

LIST YOUR CHILD'S FAVOURITE FOOD:

LIST ANY DISLIKED FOOD:

PLEASE DESCRIBE ANY PARTICULAR EATING PATTERNS:

ARE THERE ANY RELIGIOUS OR ETHNIC OBSERVANCES RELATED TO FOODS:

Sleeping

NAP TIME:	HOW LONG TO SETTLE:	TIME OF WAKING:
BED TIME:	HOW LONG TO SETTLE:	TIME OF WAKING:

IS YOUR CHILD A DEEP SLEEPER , OR DOES (S)HE AWAKEN EASILY?

DOES YOUR CHILD TAKE A FAVOURITE COMFORTER {E.G., BLANKET OR TOY} TO BED? _____ YES _____ NO

IF YES, PLEASE DESCRIBE AND TELL US IF IT IS "NAMED":

WHAT IS YOUR CHILD'S MOOD UPON WAKENING?

Toileting

IS YOUR CHILD TOILET-TRAINED? _____ YES _____ NO _____ PARTIALLY

PLEASE INDICATE YOUR CHILD'S FREQUENCY OR PATTERNS FOR BOWEL MOVEMENTS:

DESCRIBE ASSISTANCE NEEDED FOR TOILETING:

WHAT "SPECIAL " WORD DOES YOUR CHILD USE FOR: URINATION_____ BOWEL MOVEMENTS_____

Additional Child History

INJURY(S), ILLNESS(ES) OR OPERATIONS YOUR CHILD HAS HAD AND INCLUDE THE DATE(S).

a) Please describe any concerns/issues regarding your child's health (seizures, asthma, vision, hearing, etc.)

b) Please describe any concerns you may have regarding your child's development (i.e. , behaviour, vision, hearing, speech, language, mobility, etc.)

c) Describe any specific care instruction regarding a) and/or b)

OTHER HEALTH CARE PROFESSIONALS INVOLVED IN YOUR CHILD'S LIFE, E.G., OCCUPATIONAL THERAPIST/PHYSICAL THERAPIST:

Group Experiences

WHAT IS/ARE YOUR CHILD'S FAVORITE TOY(S) /ACTIVITIES:

HAS YOUR CHILD HAD PREVIOUS PLAY GROUP EXPERIENCE? _____ YES _____NO

IF YES, HOW DID HE/SHE ADAPT?

HOW DOES YOUR CHILD BEHAVE TOWARD OTHER CHILDREN {E.G., SEEKS OTHERS OUT, FEELS SHY}:

Family and General Household Information

PLEASE LIST THE NAMES OF THE SGNIFICANT PEOPLE IN YOUR CHILD'S LIFE {E.G., SIBLINGS, GRANDPARENTS, ETC.}:

PLEASE DESCRIBE THE GUIDANCE AND DISCIPLINE METHODS USED AT HOME:

PRIMARY LANGUAGE SPOKEN IN THE HOME:	OTHER LANGUAGES:

Person(s) not Authorized to Pick Up Your Child		
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

Custody Agreement:	_____ YES	_____ NO
IF YES, SUPPLY A COPY OF THE CUSTODY ORDER TO THE FACILITY MANAGER/LICENSEE		

ALTERNATE PERSON(S) TO CALL AND PICK UP CHILD IN CASE OF EMERGENCY		
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

Child's Immunization Status			
IS YOUR CHILD UP TO DATE ON IMMUNIZATIONS?	_____ YES	_____ NO	_____ NOT IMMUNIZED
COMMENTS:			

Health Information
REGULAR MEDICATION(S) AND REASONS FOR (PLEASE LIST):
ALLERGIES AND TREATMENT OF (PLEASE LIST):