ENROLMENT FORM

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Cherubs Cove Montessori Childcare Centre Inc. - Enrolment Form

CHILD'STARTING DATE:		DATE OF BIRTH:
_____/ _____/ _____	M ____ F ____	_____/ _____/ _____
MM DD YY		MM DD YY

NAME OF CHILD: _____
(Surname) (Given Names) (Also Known As)

Name the Child responds to:
_____

Address: _____

Postal code: _____
Phone: _____

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

Child's first language: _____
Other languages: _____

Days of Attendance: Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐

Parent(s) / guardian(s):

Name: _____ Home phone: _____ Cell phone: _____

Work phone: _____
E-mail: _____

Occupation: _____ Days/hours of work: _____
Name: _____ Home phone: _____ Cell phone: _____

Work phone: _____
E-mail: _____

Occupation: _____Days/hours of work: _____

Person(s) authorized to pick up the child and be contacted in case of emergency.
These people should be available during hours of care. (include mother / father / guardian):

Name: _____Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Name: _____Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Name: _____Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Has the child previously attended day-care/preschool?

Yes ☐ No ☐ if yes, how long (months): _____

Comments/instructions to help us care for your child. (Please feel free to add additional pages.):

Toileting/Diapering (special words):

_____

Rest Time (special comfort – toy/blanket):

_____

Eating/Mealtime (include food likes/dislikes):

_____

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/AGENCY	
_____	_____	Phone: _____
_____	_____	Phone: _____
_____	_____	Phone: _____

Does your child have:

Any communicable disease? YES ☐ NO ☐
If yes, please provide further information:

_____

A medical condition/concern? 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:

Medication	Times Given	Reason for Medication
_____	_____	_____
_____	_____	_____

You may be asked to complete additional forms if you answered yes to any of the above.

Custody Agreement	YES	NO	N/A	
A copy to be provided to Facility	YES	NO	N/A	
Immunization Documents Returned to Facility	YES	NO	N/A	
Information Provided By:				
	Print Name		Signature	Date
Information Received By:				
	Print Name		Signature	Date
This health information may be made available to Emergency Services				

Basic Schedule and Record of Immunization as submitted by Parent or Guardian

(ATTACH IMMUNIZATION RECORD OR RECORD THE DATES)

1st visit – 2 months of age:	**DATE**
Diphtheria	
Pertussis	
Tetanus	
Polio	
Haemophilus Influenzae Type b (Hib	
Hepatitis B	
Pneumococcal	
2nd visit – 2 months after 1st visit:	**DATE**
Diphtheria	
Pertussis	
Tetanus	
Polio	
Haemophilus Influenzae Type b (Hib	
Hepatitis B	
Pneumococcal	
3rd visit – 2 months after 2nd visit:	**DATE**
Diphtheria	
Pertussis	
Tetanus	
Polio	
Haemophilus Influenzae Type b (Hib	
Hepatitis B	
Pneumococcal	

4th visit – 12 months of age:	**DATE**
Measles	
Mumps	
Rubella	
Meningococcal C	
5th visit – 12 months after 3rd visit:	**DATE**
Diphtheria	
Pertussis	
Tetanus	
Polio	
Haemophilus Influenzae Type b (Hib	
Measles, Mumps, Rubella	
Pneumococcal	
4 – 6 years of age:	**DATE**
Diphtheria	
Pertussis	
Tetanus	
Polio	

I authorize Cherubs Cove to provide this information to physician and/or ambulance in event of an emergency.

Date:	Signature of Parent/Guardian	Signature of Childcare Provider

Date of Discharge: _____

Childcare provider: _____