

Share and Care Child Care
10 Albert Street
Stouffville, Ontario
(905) 554-0924

Emergency Information Form

Today's Date:

Child Information

Given name: _____ Surname: _____
Address: _____
Postal code: _____
Home Phone Number: _____
Date of Birth: _____

Contact People

Mother/Guardian Name: Cell Phone: Business Name: Business Phone: Business Address: Postal Code:	Father/Guardian Name: Cell Phone: Business Name: Business Phone: Business Address : Postal Code:
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<u>Emergency Contact # 1</u> Name: Relationship: Phone #: Alternate #:	<u>Emergency Contact # 2</u> Name: Relationship: Phone #: Alternate #:
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<u>Doctor</u> Name: Phone # : Address: Postal code:	<u>Special Information</u> <u>Example-Allergies, chronic conditions</u>
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Registration Form

Child

Name of Child: _____	
M <input type="checkbox"/>	F <input type="checkbox"/>
D.O.B: <u>DD/MM/YYYY</u>	
Street Address: _____	Postal Code: _____
Town: _____	Home Telephone #: () - _____
Number of Children in the Family: _____	
Ages of Children: _____	

Father

Name: _____	
Street Address: _____	Postal Code: _____
Town: _____	Home Telephone #: () - _____
Occupation: _____	
Place of Employment: _____	
Work Telephone #: () - _____	
Cell Telephone #: () - _____	

Mother

Name: _____	
Street Address: _____	Postal Code: _____
Town: _____	Home Telephone #: () - _____
Occupation: _____	
Place of Employment: _____	
Work Telephone #: () - _____	
Cell Telephone #: () - _____	

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Child's Health Care

Doctor's Name: _____	
Street Address: _____	Postal Code: _____
Town: _____	Doctor's Telephone #: () - _____

The person willing to assume responsibility for the child (in the absence of a parent) in case of accident or illness during school hours.

Name: _____	
Street Address: _____	Postal Code: _____
Town: _____	Work Telephone #: () - _____
Cell Telephone #: () - _____	Home Telephone #: () - _____

Comments: (Allergies, Sleeping Habits, Dietary Restrictions, etc.)

Signature of Parent(s)

Supervisor's Signature

Date of Child's Entry to School

Date Child's leaves School

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Medical Record

Name of Child: _____

Date of Birth: DD/MM/YY: _____

Home Address: _____

The Medical Officer of Health requires that all students to be immunized against Diphtheria, pertussis, measles, mumps and rubella.

Are there any, medical, religious or theosophical reasons why your child should or cannot be immunized? Yes _____ No _____

List any Health problems, allergies, medications taken regularly and other health concerns your child may have:

Condition	Description	Treatment Required – If any	Side affects – if any

Doctor's Name: _____

Date: _____

Doctor's address: _____

Doctor's Phone Number: _____

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Permission Form

To the Share and Care Child Care Centre:

The instructions given herein are for emergencies regarding my child/children enrolled in the school:

1. _____
2. _____
3. _____

To the Share and Care Child Care Centre:

In case of an emergency, I authorize the Share and Care Child Care Centre to call a local doctor, take the child to the nearest hospital, whichever is deemed necessary by the discretion of the school.

Signature(s) of the Parent(s) and/or guardian(s)

To the Share and Care Child Care Centre:

I hereby give permission for my child/children, attending the Share and Care Child Care Centre, to take part in excursions, which are organized and supervised by the child care centre.

Signature(s) of the Parent(s) and/or guardian(s)

To the Share and Care Child Care Centre:

I hereby give permission for my child/children attending the Share and Care Child Care Centre, to participate in any pictures taken for school use or by the media during any activity at the place of care or any outside excursions.

Signature(s) of the Parent(s) and/or guardian(s)

