

Corpus Christi Childcare Centre Full Time

2362 Waverley Avenue, Vancouver, BC V5S 0J1

Tel 604- 416-4117

APPLICATION

Current Child's Age _____

STUDENT INFORMATION

CHILD'S NAME: _____
FIRST NAME MIDDLE NAME LAST NAME (ALSO KNOWN AS)

BIRTHDATE: _____ FEMALE _____ MALE _____ BIRTH PLACE _____
Y/M/D

ADDRESS: _____

LANGUAGE SPOKEN AT HOME: _____ HOME PHONE: _____

HAS THE CHILD PREVIOUSLY ATTENDED DAYCARE.PRESCHOOL?

YES _____ NO _____ COMMENTS: _____

RELIGIOUS INFORMATION

CHILD'S RELIGION: _____ PLACE OF BAPTISM: _____ DATE OF BAPTISM: _____

PARENT'S RELIGION: FATHER: _____ MOTHER: _____

REGISTERED PARISH: _____ ENVELOPE #: _____

COMMENTS/INSTRUCTIONS TO HELP US CARE FOR YOUR CHILD

TOILETING (SPECIAL WORDS) _____

REST TIME (SPECIAL COMFORT – TOY/BLANKET): _____

EATING/MEALTIME (FOOD LIKES/DISLIKES): _____

FEARS: _____

ANY OTHER COMMENTS: _____

LEARNING CONCERNS

HAS YOUR CHILD BEEN ASSESSED OR DIAGNOSED WITH SPEECH AND LANGUAGE DISABILITIES?

YES _____ NO _____ IF YES, PLEASE SPECIFY: _____

LEARNING DISABILITIES?

YES _____ NO _____ IF YES, PLEASE SPECIFY: _____

FAMILY INFORMATION

PARENTS

MOTHER'S NAME: _____ **HOME PHONE:** _____ **CELL PHONE:** _____

OCCUPATION: _____ **WORK PHONE:** _____

DAYS/HOURS OF WORK: _____ **E-MAIL:** _____

FATHER'S NAME: _____ **HOME PHONE:** _____ **CELL PHONE:** _____

OCCUPATION: _____ **WORK PHONE:** _____

DAYS/HOURS OF WORK: _____ **E-MAIL:** _____

SIBLINGS

CHILD'S NAME: _____ **BIRTHDATE:** _____
FIRST NAME MIDDLE NAME LAST NAME Y/M/D

CHILD'S NAME: _____ **BIRTHDATE:** _____
FIRST NAME MIDDLE NAME LAST NAME Y/M/D

CHILD'S NAME: _____ **BIRTHDATE:** _____
FIRST NAME MIDDLE NAME LAST NAME Y/M/D

PERSON 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: _____ **CELL PHONE:** _____ **WORK PHONE:** _____

NAME: _____ **RELATIONSHIP TO CHILD:** _____

HOME PHONE: _____ **CELL PHONE:** _____ **WORK PHONE:** _____

NAME: _____ **RELATIONSHIP TO CHILD:** _____

HOME PHONE: _____ **CELL PHONE:** _____ **WORK PHONE:** _____

IF APPROPRIATE, LIST AN ENGLISH-SPEAKING CONTACT:

NAME: _____ **TELEPHONE:** _____

CITIZENSHIP INFORMATION

STUDENT

CANADIAN CITIZEN ____

LANDED IMMIGRANT ____

STUDENT VISA ____

PERMANENT RESIDENT OF BC ____

FATHER

CANADIAN CITIZEN ____

LANDED IMMIGRANT ____

STUDENT VISA ____

PERMANENT RESIDENT OF BC ____

MOTHER

CANADIAN CITIZEN ____

LANDED IMMIGRANT ____

STUDENT VISA ____

PERMANENT RESIDENT OF BC ____

EMERGENCY INFORMATION

DOCTOR'S NAME: _____ TELEPHONE: _____

B.C PERSONAL HEALTH CARE # _____

In the event of emergency (illness, earthquake, etc) my child may be released to the following people

NAME: _____ RELATIONSHIP TO CHILD: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

NAME: _____ RELATIONSHIP TO CHILD: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

HEALTH INFORMATION

Health professionals involved with your child (other than doctor and dentist)

NAME: _____ PROFESSION/AGENCY: _____

PHONE: _____

NAME: _____ PROFESSION/AGENCY: _____

PHONE: _____

DOES YOUR CHILD HAVE:

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 PERSCRIPTIONS AND "OVER THE COUNTER" MEDICATION 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.

THIS HEALTH INFORMATION MAY BE MADE AVAILABLE TO THE STAFF OF VANCOUVER COASTAL HEALTH

CUSTODY AGREEMENT: YES___ NO___ N/A___ **PROVIDED TO FACILITY:** YES___ NO___ N/A___

IMMUNIZATION DOCUMENTS RETURNED TO FACILITY: YES___ NO___

INFORMATION PROVIDED BY:

NAME: _____ SIGNATURE: _____ DATE: _____
Y/M/D

INFORMATION RECEIVED BY:

NAME: _____ SIGNATURE: _____ DATE: _____
Y/M/D

I certify that I am a permanent resident of British Columbia and the above information provided is correct.

SIGNATURE: _____ DATE: _____
Y/M/D

Corpus Christi Childcare Centre application does not guarantee the admission to Corpus Christi School. There is a different application form to submit.