

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 _____ BIRTHPLACE _____
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): _____

MEAL TIME: _____ FOOD LIKES AND 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 ATTENDING CORPUS CHRISTI SCHOOL

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

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CHILD'S NAME: _____ **BIRTHDATE:** _____
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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 (Please check)

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: _____

YOU MAY BE ASKED TO COMPLETE ADDITIONAL FORMS IF YOU ANSWERED YES TO ANY OF THE ABOVE.

LIST ALL PERSCRIPTIONS AND “OVER THE COUNTER” MEDICATION YOUR CHILD RECEIVES:

| MEDICATION | TIMES GIVEN | REASON FOR MEDICATION |
|------------|-------------|-----------------------|
| | | |
| | | |
| | | |

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 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.

