COUCHICHING CHILD CARE CENTRE

Registration Form

Childs Information

Childs Name: _____ Birthday: _____

Address: _____ Town: _____

Province: _____ Postal Code: _____

Phone: _____

Nickname (if any) _____ Traditional Name: _____

Mother/Guardian Information

Name: _____ Home Telephone: _____

Cell: _____ Address: _____

Town: _____ Province: _____

Postal Code: _____ Occupation: _____

Business Address: _____ Work Telephone: _____

Fathers Information

Name: _____ Home Telephone: _____

Cell: _____ Address: _____

Town: _____ Province: _____

Postal Code: _____ Occupation: _____

Business Address: _____ Work Telephone: _____

Medical History

Family Physician: _____ Phone: _____

Full Address: _____

Childs previous history of communicable diseases: _____

_____

_____

Does your child need regular medication for health problems? YES ( ) NO ( )

If Yes what and when is it given: _____

_____

Childs Allergies? YES ( ) NO ( ) If YES list allergies: _____

Special instructions in the event of an allergic reaction: _____

_____

Record of immunization (if child has not been immunized, a parent of the child must provide a written statement that immunization conflicts with the sincerely held convictions of the parent(s) religion or conscience or a legally qualified medical practitioner must give medical reasons in writing as to why the child should not be immunized) Please circle

Diphtheria Pertussis Tetanus Polio Rubella Mumps Measles

Please attach a copy of immunization record

Does your child have any mental or physical disabilities? YES ( ) NO ( )

If YES explain: _____

_____

Emergency Contact Information

Name of the person to be contacted if parent cannot be reached in case of emergency during hours of care. Be advised that no children under the age of 16 years of age will not be allowed to pick up your child.

Primary Contact Person

Name: _____ Home telephone _____

Address: _____ Work telephone _____

Cell: _____ Relationship to child: _____

Secondary:

Name: _____ Home telephone: _____

Address: _____ Work telephone: _____

Cell: _____ Relationship to the child: _____

Name: _____ Home telephone: _____

Address: _____ Work telephone: _____

Cell: _____ Relationship to the child: _____

Name: _____ Home telephone: _____

Address: _____ Work telephone: _____

Cell: _____ Relationship to the child: _____

Questionnaire:

What are your childs sleeping habits? _____

_____

What are your childs likes and dislikes with food? _____

_____

Is your child potty trained? YES ( ) NO ( ) _____

Is your child self -sufficient in the bathroom? YES ( ) NO ( ) _____

Special requirements for diet, rest or exercise? _____

_____

_____

Please comment on your childs developmental (eg. Habits, favorites, activities, fears etc.)

_____

_____

_____

Any previous Child Care Centre that your child has attended: _____

Any Problems: _____

Other Information: _____

_____

_____

Parents Signature: _____

Supervisors Signature: _____

Date: _____

****

Office Use Only

Date of Entry: _____

Date of Exit: _____

Reason for Completion: _____

Couchiching Child Care Centre

Emergency Information

Childs Name:

Mothers Name:

Home Phone: Work Phone:

Cell:

Fathers Name:

Home Phone: Work Phone:

Cell:

Name of Person(s) to contact if parent(s)/guardians cannot be reached:

1st: Home/Work/ Cell Numbers:

2nd: Home/Work/Cell Numbers

Physician Name:

Address:

Phone Number:

Medical/ Allergy Information

Four C's

Couchiching Child Care Centre

Program: Couchiching Child Care Centre
Behavior Management policy for Parent(s) / Guardians / Visitors

In order to ensure the safety, security and respectful atmosphere for our children, staff and others in the Couchiching Childcare Centre, the following policy is in effect:

There will no verbal, physical or other use of any manner to be used in the presence of any child, staff member, or other persons in the Couchiching Childcare Centre.

There will be zero tolerance of any foul language, racial slurs, physical abuse or yelling at any person's in the presence of any child or staff at the Couchiching Childcare Centre.

There will be zero tolerance for any non-compliance of
Couchiching Childcare Philosophy.

Any infractions of these guidelines will result in immediate corrective action. Depending on the severity of actions an immediate permanent discharge from the childcare may be involved.

All facts, and remarks made during the incident will be kept on file.

The appropriate authorities will be given a statement regarding the incident.

Parent(s) / Guardian _____ Date _____

Site 206-95, R.R.#2, Fort Frances, Ont. P9A 3M3 Phone 807-274-0456 Fax 807-274-1441

Four C's
Couchiching Child Care Centre

Program: Couchiching Child Care Centre
Behavior Management policy for Parent(s) / Guardian / Visitors

If any parent/guardian/ visitor becomes verbally/physically abuse to Administration staff, Student Teachers, Volunteers or children of the Centre:

Procedure:

First Incident: Staff documents incident and the parent is provided with a written warning that must be signed by the parent, staff, and supervisor.

Second Incident: the supervisor will consult the Chief and Council. The family will be notified in writing of termination of services.

If parent(s) / guardian fail to comply with policies and procedures agreed upon at enrollment:

Procedure:

First Incident: Meeting with the Supervisor to discuss issue.

Second Incident: Written warning signed by parent(s) / guardians, supervisor and Chief and Council.

Third Incident: The Chief and Council will be consulted by the supervisor. The family will be notified in writing of termination of services.

1st Parent(s) / Guardians Signature _____

2nd Parent(s) / Guardians Signature _____

Date _____

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Four C's
Couchiching Child Care Centre

Emergency Medical Attention

I _____ grant permission for the Child Care Centre staff to take whatever steps may be necessary to obtain emergency medical care for my child_____
In the event of injury or illness while he/she is in attendance at the above Child Care Centre.

I understand that these steps may include but are not limited to the following:

1. The child will receive immediate preliminary first aid treatment from a Child Care staff member.
2. Child Care staff will attempt to obtain the immediate service of the community health worker, physician, or health nurse or other medical practitioner.
3. Child Care Centre staff will attempt to contact the childs parent/guardian or any of the contact people, if they cannot be reached, arrangements will be made to transport the child for emergency treatment at the nearest hospital in the company of a Child Care staff member.

I realize that every precaution will be taken to ensure the health, safety and well- being of all children in care and I hereby release the above Child Care Centre and its staff members from liability regarding injury or illness involving my child while he/she is in attendance.

_____ _____

Signature of Parent/Guardian Date

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Protected B

Health Canada / Santé Canada

THE CHILDREN'S ORAL HEALTH INITIATIVE

AUTHORIZATION FORM

Grade_____

To be completed by Parent, Guardian or Authorized Representative

Please print the name of the child you are authorizing to receive dental services:

Child's Legal Last Name	Child's Legal First Name	M / F (sex)	Date of Birth (Year/Month/Day)	Registration/Treaty or N # (9 or 10 digit number)

Health History of the child named above:

	Yes	No	Don't know?
Does the child have any heart problems?	☐	☐	☐
Does the child have any bleeding problems?	☐	☐	☐
Does the child have any allergies?	☐	☐	☐
If yes, please explain: _____			
Does the child have any other health conditions?	☐	☐	☐
If yes, please explain: _____			
Does the child take any fluoride supplements (i.e.: drops or tablets)?	☐	☐	☐

By signing below I, _____,

A) give my authorization for the child (named above) to receive any of the following dental services:

- screening
- fluoride varnish
- temporary fillings
- dental sealants
- instruction on healthy dental habits

Complications or reactions to these procedures are unusual. However, if the child has any complications or reactions to these services, please contact a nurse or dental professional.

Canada

Health Canada / Santé Canada

B) give my authorization for Health Canada to collect, use and disclose information about the child for the purposes of the First Nations and Inuit Health Branch (FNIHB) Children's Oral Health Initiative;

C) understand that the personal information of the child is protected under the *Privacy Act* and the information may only be used or disclosed within the conditions set out in that Act;

D) understand that dental program records and data information may be used by FNIHB, Health Canada, for management and administration purposes only directly related to FNIHB Children's Oral Health Initiative;

E) confirm that I have read and understand the content of this Authorization Form;

F) choose to give my consent voluntarily;

G) understand that this consent will remain in effect until it is withdrawn in writing by a parent, guardian or authorized representative of the above-named child.

Parent, Guardian or Authorized Representative, please <u>print</u> your name and telephone number:

Last Name of Parent, Guardian or Authorized Representative	First Name of Parent, Guardian or Authorized Representative	Telephone number

Signature of Parent, Guardian or Authorized Representative

Today's Date (Year/Month/Day)

Canada

Four C's
Couchiching Child Care Centre

Outing Permission

I give my permission for my child _____

To be taken on local outings or excursions by the Child Care Centre staff. Local outings may include walks, picnics or visits to places of interest in the community. I understand that I will be given prior notice and will have the opportunity to give consent in writing regarding any other major outings that are organized. I have read and fully understand the above.

_____ _____

Signature of Parent/Guardian Date

****

Photograph Permission

I give my permission for my child _____

to be photographed, videotaped or audio taped while at the Child Care Centre or on field trips. I understand that the result of the photographs, video or audio tapes may be used for publicity or promotion of the program. All videos, brochures and materials will be used to promote Quality Child Care that is developmentally and culturally appropriate. I have read and fully understand the above.

_____ _____

Signature of Parent/Guardian Date

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Four C's

Couchiching Child Care Centre

WAIVER OF EMPLOYMENT VERIFICATION

I give the Supervisor, Assistant Supervisor and or the Administrator of the Couchiching Child Care Centre permission to contact my place of employment and/or Educational Institute.

_____

Place of Employment / School & Name of Contact Person

Where they will verify that I am employed / attending the following days and hours:

Monday _____

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

I give this permission on the understanding that the information obtained will be kept for is only by the Couchiching Child Care Centre and handled in a professional matter.

_____ _____

Signature of Employee / Student Date

_____ _____

Signature of Witness Date

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Signature of Employee / Student Date

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Signature of Witness Date

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