



## LITTLE CHAMPIONS DAYCARE AND OUT OF SCHOOL CARE- REGISTRATION PACKAGE

### REGISTRATION FORM

**Registration Fee:** A \$100.00 non-refundable deposit is required by Cheque along with the registration package to secure admission. This will be adjusted towards the first monthly fees.

#### PROGRAM INFORMATION

<b>CHILDCARE PROGRAM:</b>	
START DATE (YY/MM/DD):	END DATE (YY/MM/DD):

#### CHILD INFORMATION

Child's Last name:	Child's First Name:	
Child Prefers to be called:		
Birth Date (YY/MM/DD)	Gender:	
Address:	City	Postal Code
Home Phone:	Cell Phone:	
Preferred Email:		

#### PARENT / GUARDIAN # 1

Last name:	First Name:	
Address (Same as Child): Yes <input type="checkbox"/> No <input type="checkbox"/>		
Address:	City	Postal Code
Home Phone:	Work Phone:	
Preferred Email:	Relation to child:	

#### PARENT / GUARDIAN # 2

Last name:	First Name:	
Address (Same as Child): Yes <input type="checkbox"/> No <input type="checkbox"/>		
Address:	City	Postal Code
Home Phone:	Work Phone:	
Preferred Email:	Relation to child:	

<b>FOR OFFICE USE ONLY</b>	
Start Date (YY/MM/DD)	Monthly Fee:
<b>REGISTRATION SERVICES USE</b>	
<input type="checkbox"/> All required documents submitted	
Missing Information:	

Last Updated on: \_\_\_\_\_

Date: \_\_\_\_\_ Initials: \_\_\_\_\_

**AUTHORIZED PICK UP LIST**

Child's Last Name:

Child's First Name:

**AUTHORIZATION**

I authorize the following people (in addition to Parent / Guardian 1 and 2) to pick up my child and / or to be contacted in case of emergency

**Contact # 1**

Last name:	First Name:	
Address:	City	Postal Code
Home Phone:	Work Phone:	
Preferred Email:	Relation to child:	

**Contact # 2**

Last name:	First Name:	
Address:	City	Postal Code
Home Phone:	Work Phone:	
Preferred Email:	Relation to child:	

**Contact # 3**

Last name:	First Name:	
Address:	City	Postal Code
Home Phone:	Work Phone:	
Preferred Email:	Relation to child:	

**PLEASE INDICATE PERSON(S) TO WHOM WE MAY NOT RELEASE YOUR CHILD  
(NAME & DESCRIPTION)**

Last Name:

First Name:

Last Name:

First Name:

**CHILD'S PERSONAL INFORMATION**

Child's Last Name:

Child's First Name:

**CHILD'S HOME INFORMATION**

Child Lives with?    Both Parents ☐    Mother ☐    Father ☐    Guardian 1 ☐    Guardian 2 ☐  
Other Siblings in home?    ☐ Yes    ☐ No  
Other Adults in home?    ☐ Yes    ☐ No

If yes, please include name(s):

Last name:

First Name:

Last name:

First Name:

**IF THERE IS A CUSTODY AGREEMENT**Is there a copy of the agreement attached    ☐ Yes    ☐ No

Please provide details:

**SOME OTHER DETAILS:**

Bed time: \_\_\_\_\_

What language(s) is / are spoken at home: \_\_\_\_\_

In what areas does your child have particular interest: \_\_\_\_\_

Festivals celebrated: \_\_\_\_\_

**Speech Development**Uses Words Only ☐Speaks in Sentences ☐Speaks in Phrases ☐Comments:**CHILD'S HEALTH INFORMATION**

Child's Last Name:	Child's First Name:
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ALBERTA HEALTH CARE PERSONAL HEALTH NUMBER:

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## IMMUNIZATION RECORDS

The Child Care Licensing Regulation requires that we have immunization records for each child in our program.

Please enter dates of immunization in the assigned space, or submit a copy of your child's immunization records available from your local health unit. PENTA; Combines Pertussis, Tetanus, Diphtheria, Polio, Haemophilus Influenza B in one dose

Date / Age	Date / Age
PENTA or DPTP _____	Measles _____
PENTA or DPTP _____	Mumps _____
PENTA or DPTP _____	Rubella _____
PENTA or DPTP _____	Hepatitis B _____
DPTP _____	TB _____
<input type="checkbox"/> I have chosen not to immunize my child.	Signature _____
<input type="checkbox"/> My child's immunizations are not up-to-date	Signature _____

## FAMILY DOCTOR

Name:	Phone:
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## FAMILY DENTIST

Name:	Phone:
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## ALLERGIES

Food Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please Specify: _____
			Severity of Reaction: _____
Other Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please Specify: _____

Severity of Reaction:

\_\_\_\_\_

Does Your Child use an epi-pen or inhaler? ☐ Yes ☐ No

If yes, provide details: \_\_\_\_\_

**PARENT PERMISSIONS/CONSENT**

Child's Last Name:

Child's First Name:

**IMAGE RELEASE**

I \_\_\_\_\_ (parent / guardian) give my permission for video, photo and digital images of my child to be taken during the program for in-house purposes. I understand that the name of my child will not be published without my express written permission.

Parent / Guardian signature \_\_\_\_\_ Date: \_\_\_\_\_

**FIELD TRIPS**

I \_\_\_\_\_ (parent / guardian) give my permission for my child to accompany child care staff on short neighbourhood trips (i.e library, local park). I understand that all excursions will be carefully pre-planned and adequately supervised. I understand that I will be informed of field trips that require public transportation and / or take place outside of the immediate neighbourhood of the child care centre.

Parent / Guardian signature \_\_\_\_\_ Date: \_\_\_\_\_

**PERMISSION TO ADMINISTER SUNSCREEN**

I \_\_\_\_\_ (parent / guardian) give my permission to the Little Champions Daycare/OSC staff to apply sunscreen to \_\_\_\_\_ (child) on as-needed basis. If sunscreen is not provided by the family, the staff will administer sunscreen.

Parent / Guardian signature \_\_\_\_\_ Date: \_\_\_\_\_

**PARENT CONSENT**

In permitting my child to attend the Little Champions Daycare, I, the undersigned, permit my child to participate in the full range of child care activities and authorize the Director or their appointee, in the event of an accident or illness affecting the above named child, to authorize on my behalf all procedures, including admission to hospital and any necessary treatment there in as he/she may deem essential for the care and well-being of the child. Such action is only to be taken when immediate

contact with the undersigned cannot be made. It is understood that the Little Champions Daycare / OSC is not responsible for medical care or ambulance costs.

Parent / Guardian signature \_\_\_\_\_ Date: \_\_\_\_\_

#### PRIVACY POLICY

As the Little Champions Daycare / OSC, your privacy is, and always has been, very important to us. We are dedicated to providing you with superior service while protecting your privacy and safeguarding your personal information by following responsible information handling practices in keeping with privacy laws.

#### PAYMENT INFORMATION

Child's Last Name:

Child's First Name:

Last Name:

First Name:

Address ☐ same as child

City:

Postal Code:

Main phone / Cell  
phone:

Work Phone:

Email:

In accordance with Canadian Revenue Agency guidelines, Child Care tax receipts will be issued in the name of the payer

#### PAYMENT OPTIONS

Please indicate your preferred method of payment. All Childcare payments are withdrawn on the 1<sup>st</sup> of every month through Pre-Authorized Debit (PAD).

☐ I would like to pay by pre-authorized debit (PAD) and have attached a void cheque to this registration.

☐ I will make cheque payment by the 5<sup>th</sup> of every month.

#### PRE-AUTHORIZED PAYMENT CONDITIONS AND AUTHORIZATION

I hereby authorize The Little Champions Daycare / OSC to deduct monthly child care fees from my bank account, financial institution or credit card on the first (1st) of each month. If funds are unavailable, the Little Champions Daycare / OSC will attempt to withdraw fees a second time (upto 30

days from original payment date). The Little Champions Daycare / OSC will not be responsible for any costs charged by my bank / financial institution. These services are for my personal purposes.

To make changes to your account information, ten (10) days notice is required, prior to the First (1<sup>st</sup>) of the month. It is the responsibility of the parent to ensure that the Little Champions Daycare / OSC has the current address.

My child care services may be cancelled if payment is not received for child care fees.

Child Care fees are subject to annual increases, however, parents / guardians will be notified forty-five (45) days in advance of any such increases. Any fee increases or changes will be adjusted accordingly.

I may revoke my authorization at any time, by providing written notice of 30 days. I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or inconsistent with this PAD agreement.

In the event I want to make changes to the program my child attends or to withdraw my child from the program, I agree to provide forty five (45) days notice. For example, to withdraw from Aug 1<sup>st</sup>, written notice would be required on or before June 15<sup>th</sup>.

Payer Signature\_\_\_\_\_ Date\_\_\_\_\_

Parent/ Guardian signature (if not payer)\_\_\_\_\_ Date\_\_\_\_\_