

Child Care Centre Application for Enrolment

Name of Child Care Centre: **WHISTLE STOP CO-OP PRESCHOOL**

Age Group Placement at Time of Enrolment:

Preschool 9:00am – 11:30am

Morning Requested:

MON	WED	FRI

For Office Use Only

Date of Admission: dd/mm/yyyy

Date of Discharge: dd/mm/yyyy

Child Information

Full Legal Name:	Preferred Name:
Date of Birth (dd/mm/yyyy):	Age (years, months):
Complete Home Address – including postal code	
Language(s) Spoken at Home:	
Other children in the family enrolled in the centre (list names, if applicable):	

Parent Information

Full Legal Name:	Preferred Name:
Relationship to Child:	Primary Phone Number:
Alternate Phone Number:	Email address(es):
Home Address: <input type="checkbox"/> Same as Child	

Full Legal Name:	Preferred Name:
Relationship to Child:	Primary Phone Number:
Alternate Phone Number:	Email address(es):
Home Address: <input type="checkbox"/> Same as Child	

Custody Arrangements (if applicable)

Are there custody arrangements pertaining to legal right of access to your child? YES NO

If YES, please provide a copy of the appropriate legal documentation (e.g., court order).

Name(s) of custodial parent(s): _____

Name(s) of individuals prohibited from accessing/picking up your child: _____

Emergency Contacts

In the event of an emergency, if a parent cannot be reached, the following individual(s) may be contacted. Please list in order of preference.

Emergency Contact #1	Emergency Contact #2
Full Legal Name:	Full Legal Name:
Preferred Name:	Preferred Name:
Relationship to Child:	Relationship to Child:
Primary Phone Number:	Primary Phone Number:
Alternate Phone Number:	Alternate Phone Number:
Home Address:	Home Address:
<input type="checkbox"/> Authorized to pick-up child	<input type="checkbox"/> Authorized to pick-up child

Pick-Up Authorization

The following additional individuals are authorized to pick up my child (Photo ID will be required to confirm identify before the child will be released):

Full Legal Name	Relationship to Child	Primary Phone

Additional Emergency Information

Please provide any special medical or additional information about your child that could be helpful in an emergency (e.g., known medical conditions, skin conditions, vision/hearing difficulties):

Health Information

Doctors Name:

Phone Number:

Home Address: (please include postal code)

If your child has had any history of communicable diseases (e.g., chicken pox, measles), please list them

Does your child have any medical need(s) that requires additional support (e.g., Diabetes)?

YES NO

If yes, an individualized plan for children with medical needs must be developed between the parent and the child care centre prior to the child's first day of care.

Allergy Information

Does your child have a life-threatening allergy (e.g., anaphylactic to peanuts or bee stings)?

YES NO

If yes, an individualized plan for an anaphylactic allergy that includes emergency procedures must be developed between the parent and the child care centre prior to the child's start date.

Does your child have any allergies that are not life-threatening (food or other substance [e.g., latex])?

YES NO

If yes, please provide relevant details, including what your child is allergic to, symptoms of a reaction and treatment required:

Physical Requirements

Does your child use diapers or pull-ups?

YES NO

If no, my child:

Uses the washroom independently Requires some assistance Requires full support

Please provide relevant details:

Additional Information

Please indicate any additional information that is relevant to the care of your child (e.g., prone to colds, frequent shoulder dislocation, etc.):

Parent Name

Parent Signature

Date (dd/mm/yyyy)

Staff Name

Staff Signature

Date (dd/mm/yyyy)

Note: 'Parent' is defined as a person having lawful custody of a child or person who has demonstrated a settled intention to treat a child as a child of his or her family, and includes legal guardians.

Immunization Records

Please provide TWO COPIES of your child's immunization record (e.g., yellow card) to the centre prior to your child's first day of care.

If you have chosen not to immunize your child, a [Statement of Medical Exemption](#) form or a [Statement of Conscious or Religious Belief](#) form must be completed and provided to the centre. These forms are available on the Ministry of Education's website.

****A \$40 one-time administration fee is due with the package ***

Child's Emergency Contact Information

WHISTLE STOP CO-OP PRESCHOOL

Child's Information	
Full Legal Name:	Preferred Name (where applicable):
Date of Birth (dd/mm/yyyy):	
Special Medical or Additional Information Helpful in an Emergency (e.g., allergies, known medical conditions):	
Parent	Parent
Full Legal Name:	Full Legal Name:
Preferred Name:	Preferred Name:
Preferred Phone Number:	Preferred Phone Number:
Alternate Phone Number:	Alternate Phone Number:
Emergency Contact	Emergency Contact
Full Legal Name:	Full Legal Name:
Relationship to child:	Relationship to child:
Preferred Phone Number:	Preferred Phone Number:
Alternate Phone Number:	Alternate Phone Number:
Doctors Name:	
Address:	Phone Number:

Medical Release:

If at any time, due to circumstances such as an accident, sudden illness or emergency, medical treatment is required, this may be given, including anaesthetic necessary, by a private physician or hospital. I also consent to emergency transportation if necessary.

Signature of Parent or Guardian: _____ Date: _____

Immunization Information for Licensed Child Care Settings

1. Name of Child Care Centre: _____

Please check off the box that best describes your child:

<input type="checkbox"/> Pre-School Program	start date: _____ / _____ YYYYYY MM	
<input type="checkbox"/> JK or SK Program (at child care centre)		start date: _____ / _____ YYYYYY MM
<input type="checkbox"/> Before School Program	start date: _____ / _____ YYYYYY MM	_____ Name of Elementary School Attending
<input type="checkbox"/> After School Program	start date: _____ / _____ YYYYYY MM	_____ Name of Elementary School Attending

2. Personal Information (Please PRINT clearly)

Child's information (please print name as it appears on school registration):

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ / _____ / _____

YYYYY MM DD

Gender: M (male) F (female) X (gender neutral)

Ontario Health Card # _____ Version Code _____

Street Address: _____ Unit/Apt: _____

City/Town: _____ Postal Code: _____

Name of Doctor: _____ Doctor's Phone #: (_____) _____

Parent/Guardian Information:

Last Name: _____ First Name: _____ Relationship to Child: _____

Last Name: _____ First Name: _____ Relationship to Child: _____

Home/Cell Phone #: (_____) _____ Work Phone #: (_____) _____

3. Immunization Record:

Please attach a photocopy of your child's immunization record(s).
Please make sure that the record also contains your child's name and birth date.

PLEASE NOTE:

Parents /guardians of children in child care centres will be required to follow Ontario's Publicly Funded Immunization Schedule. The vaccine recommendations include immunization against the following vaccine preventable diseases: diphtheria, measles, mumps, poliomyelitis, rubella, tetanus, pertussis, meningococcal, varicella, and haemophilus influenzae type b. Vaccines for pneumococcal, rotavirus and annual influenza vaccine are also strongly encouraged.

In order to attend licensed child care in Wellington-Dufferin-Guelph, you must provide one of the following:

- A complete history of your child’s immunizations to Public Health (Medical Officer of Health)

OR

- One of the following **Ministry of Education Child Care and Early Years Act, 2014** exemption forms:
 - [Statement of Conscience or Religious Belief](#)– which must be signed by a Commissioner for Taking Affidavits.
 - [Statement of Medical Exemption](#) – which must be signed by a healthcare provider and include their license or registration number.

Please note that the **Ministry of Education child care specific exemption forms** will expire once your child is enrolled in school and a new **Ministry of Health and Long-Term Care exemption form and education requirement** or medical exemption form under the *Immunization of School Pupils Act* will be required at the time of school entry.

It is the responsibility of the parent/guardian to maintain up to date immunization records for their child(ren). When additional immunizations are given please report them to Wellington-Dufferin-Guelph Public Health:

- Online at www.immunizewdg.ca.
- By completing the enclosed form and attach a photocopy of the immunization record. You can either give the completed form to your child care centre **OR** you can mail or drop it off at the following address:
Vaccine Records, 160 Chancellors Way, Guelph, Ontario N1G 0E1

If you are unable to complete this form or cannot locate your child’s immunization record, please contact your health care provider for further assistance.

Date of Submission: _____ **Parent/Guardian Signature:** _____
yy/mm/dd

The information on this form is collected under the authority of the *Health Protection and Promotion Act* in accordance with the *Municipal Freedom of Information and Protection of Privacy Act* and the *Personal Health Information Protection Act*. This information will be used for the delivery of public health programs and services; the administration of the agency; and the maintenance of healthcare databases, registries and related research, in compliance with legal and regulatory requirements. Any questions about the collection of this information should be addressed to the Chief Privacy Officer at 1-800-265-7293 ext 2975.