Enrollment Form

TEAM Child Care Center
10300 Yonge St.
Richmond Hill, ON, L4C 3B8

Age Group Placement:	☐Toddler ☐ Preschool ☐ Kindergarten			
Type of Child Care Required:	☐ Full-time ☐ Part-time			
If its part time, days of care	☐ MON ☐ TUE ☐ WED ☐ THU ☐ FRI			
Child's Full Name				
Date of Birth (MM/DD/YYYY):		**Gender: M** ☐ **F** ☐	**Start Date (MM/DD/YYYY)**	
Home Address (street):				
City:			**Postal code**	
Home phone number:				
Allergies:				
Diet restrictions: (e.g., vegetarian, kosher, halal)? YES ☐ NO ☐	**If Yes, please provide relevant details:**			
Sleep Arrangements: (e.g., specific comfort item, soother) YES ☐ NO ☐	**If Yes, please provide relevant details:**			
At what times does your child typically nap?				
Physical Requirements Does your child require any additional support or accommodation with respect to physical activity? YES ☐ NO ☐	**If Yes, please provide relevant details:**			
Does your child use diapers? YES ☐ NO ☐	**If no, my child:** ☐ Uses the washroom independently ☐ Requires some assistance ☐ Requires full support			
Medications:				
Pediatrician / family doctor:		**Phone:**		
Doctor's address:				

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Health Information

If your child has had any history of communicable diseases (e.g., chicken pox, Acquired immunodeficiency syndrome, hepatitis, tuberculosis, measles etc), please list them below:

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 Team 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:

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Immunization Records

Please provide an updated copy 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 (The form can be found on Ministry of Education website or the copy of the form can be obtain in the office).

For office use:

Vaccine (Age Usually Given)	Date of Immunization	Date of Immunization	Date of Immunization	Date of Immunization
DTaP-IPV-Hib (2 mos, 4 mos, 6 mos, 18 mos) Diphtheria, Tetanus, Pertussis, Polio, *Haemophilus influenzae* type b				
Pneu-C-13 (2 mos, 4 mos) Pneumococcal Conjugate 13				
Rot-1 (2 mos, 4 mos) Rotavirus				
Men-C-C (12 mos) Meningococcal Conjugate C				
MMR (12 mos) Measles, Mumps, Rubella				
Var (15 mos) Varicella				
MMRV (4-6 years) Measles, Mumps, Rubella, Varicella				
Tdap-IPV (4-6 years) Tetanus, diphtheria, pertussis, Polio				
Inf (every year in the fall) Influenza				
Other (please specify)				

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Parent's information

Parent #1 Full Legal Name		**Relationship to the child**	
Home address			
Home Phone Number:		**Cell:**	
Email:			
Employer:		**Work Phone number**	
Parent #2 Full Legal Name		**Relationship to the child**	
Home address			
Home Phone Number:		**Cell:**	
Email:			
Employer:		**Work Phone number**	

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:

_____

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Emergency Contacts

In the event of an emergency, if a parent cannot be reached, the following individual(s) may be contacted and are authorized to pick up my child. Please list in order of preference. (**Photo ID** will be required to confirm identify before the child will be released):

Emergency Contact #1 Full /preferred name:		**Relationship to child**	
Phone:		**Cell/Phone:**	
Home Address		**Authorized to pick up** YES ☐	
Emergency Contact #2 Full /preferred name:		**Relationship to child**	
Phone:		**Cell/Phone:**	
Home Address		**Authorized to pick up** YES ☐	

Parent/Guardian Signature: _____ **Date:** _____

Supervisor's Signature _____ **Date:** _____