2663 West King Edward Vancouver, BC V6L 1T5, Tel: 604 568 8059, Email: info@creativekidsmontessori.com

REGISTRATION FORM

CHILD'S STARTING DATE	DATE OF BIRTH	SEX
_____/ _____/ _____/	_____/ _____/ _____/	M ❑ F ❑
YEAR MONTH DATE	YEAR MONTH DATE	

NAME OF CHILD: _____

(SURNAME, GIVEN NAME, ALSO KNOWN AS)

NAME CHILD RESPONDS TO: _____

ADDRESS: _____ **POSTAL CODE:** _____

PHONE: _____

PERSON(S) WITH WHOM CHILD LIVE (ADULTS & CHILDREN:)

CHILD'S FIRST LANGUAGE: _____ SECOND LANGUAGE: _____

PARENT(S)/GUARDIAN(S)

NAME:_____HOME PHONE: _____
WORK PHONE:_____LOCAL: DAY/HOURS OF WORK: _____
EMAIL:

NAME:_____HOME PHONE: _____
WORK PHONE:_____LOCAL: DAY/HOURS OF WORK: _____
EMAIL: _____

PERSON(S) AUTHORIZED TO PICK UP CHILD AND/OR BE CONTACTED IN CASE EMERGENCY(INCLUDE: MOTHER / FATHER / GUARDIAN)

NAME:_____RELATIONSHIP TO CHILD:_____
HOME PHONE:_____WORK PHONE: _____

NAME:_____RELATIONSHIP TO CHILD:_____
HOME PHONE:_____WORK PHONE: _____

NAME:_____RELATIONSHIP TO CHILD:_____
HOME PHONE:_____WORK PHONE: _____

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REGISTRATION FORM

IF APPROPRIATE, ENGLISH SPEAKING CONTACT

NAME:_____ PHONE: _____

IF THERE IS A CUSTODY AGREEMENT, PLEASE GIVE DETAILS AND ATTACH COPY

_____

_____

HAS CHILD PREVIOUSLY ATTENDED DAYCARE / PRESCHOOL

YES: ❑ NO: ❑ IF YES, WHERE? _____

COMMENTS / INSTRUCTIONS TO HELP US CARE FOR YOUR CHILD

TOILETING / DIAPERING:_____

REST TIME: _____

EATING / MEALTIME:_____

FEARS: _____

HEALTH INFORMATION

FAMILY DOCTOR: _____ PHONE: _____

FAMILY DENTIST:_____ PHONE: _____

OTHER HEALTH PROFESSIONALS INVOLVED WITH YOUR CHILD

_____ PHONE:_____

_____ PHONE:_____

_____ PHONE: _____

PERSONAL HEALTH NUMBER

_____

DATE EFFECTIVE

_____/_____/_____/

YEAR MONTH DATE

IF APPROPRIATE, COMMENT ON THE FOLLOWING HEALTH ISSUES

SPECIAL MEDICATIONS:_____

VISION OR HEARING: _____

ALLERGIES:_____

SPEECH OR LANGUAGE:_____

OTHER: _____

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REGISTRATION FORM

PARENTS' COMMENTS (IF ANY)

_____

_____

_____

_____

_____

_____

_____

*This health information is to be made available to the staff of the **Vancouver Health Department***

SIGNATURE OF PERSON PROVIDING INFORMATION: _____

SIGNATURE OF PERSON RECEIVING INFORMATION: _____

DATE: _____/ _____/ _____/
YEAR MONTH DATE