Penpals Montessori Children's House Registration Form

CHILD'S STARTING DATE: _____/_____/_____
YY MM DD

DATE OF BIRTH: _____/_____/_____
YY MM DD

SEX: **M_____ F_____**

NAME OF CHILD: _____
(Surname) (Given Names) (Also Known As)

Name the child responds to: _____

Address: _____

Postal Code: _____ Phone: _____

Person(s) whom the child lives [adults and children]: _____

Child's first language: _____ Other languages: _____

Parent(s)/guardian(s):

Name: _____ Home phone: _____ Cell phone: _____

Work phone: _____ Days/Hours of work: _____ E-mail: _____

Name: _____ Home phone: _____ Cell phone: _____

Work phone: _____ Days/Hours of work: _____ E-mail: _____

Person(s) authourized to pick up the child and be contacted in case of emergency:
(include mother/father/guardian)

Name: _____ Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Name: _____ Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Name: _____ Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Name: _____ Relationship to child: _____

Home phone: _____ Work phone: _____ Cell phone: _____

If appropriate, list an English speaking contact:

Name: _____ Phone: _____

If there is a custody agreement, please give details and attach copy:

_____

_____

Has the child previously attended daycare/preschool?

YES_____ NO_____ If **YES**, where? _____

Comment/instructions to help us care for your child:

Toileting/Diapering: _____

Rest time: _____

Eating/Mealtime: _____

Fears: _____

Health information

Care Card Personal Health No.: _____

Family Doctor: _____ Phone: _____

Family Dentist: _____ Phone: _____

Other health professionals involved with you children:

_____ Phone: _____

_____ Phone: _____

If appropriate, comment on the following health issues:

1. Special Medication: _____

2. Speech or Language: _____

3. Vision or Hearing: _____

4. Allergies or Asthma: _____
   (a) Does the child and/or family (ie. parents and siblings) have a history of allergy or asthma? _____
   (b) Has the childhad a number os surgeries? _____
   If the answer to either 4(a) or (b) is **YES**, fill out a **CHILD ALLERGY/ASTHMA INFORMATION FORM**

5. Other (Specify): _____

Parent's Comments (if any):

_____

_____

This health information is to be made available to the staff of Penpals Montessori Children's House. I hereby give my consent to PMCH to use and disclose my personal information for school purposes only.

Information Provided By: _____ (Print Name) _____ (Signature)

Information Received By: _____ (Print Name) _____ (Signature)

DATE: _____/_____/_____
YY MM DD