Confidential When Completed

TSAWOUT FIRST NATION
XE,NE,SEN Child Care Center

REGISTRATION FORM

Date of Registration: _____
Day/Month/Year

Child

Name of Child: _____
Surname Given Name Middle Name

Status and Band Number: _____

Name Child Responds to: _____

Street Address: _____

Mailing Address: _____

Sex: M _____ F _____ Date of Birth: _____ Phone: _____
Day/Month/Year

Child's First Language: _____ Second Language: _____

Parent/Guardian

Name: _____

Place of work: _____ Phone: _____Local _____

Home Address: _____

Name: _____

Place of work: _____ Phone: _____Local _____

Home Address: _____

Medical Information:

Personal Health Number: _____ Date Effective: _____

Family Doctor: _____ Phone: _____

Family Dentist: _____ Phone: _____

Alternate Person To Call In Case of Emergency

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Persons Authorized to Pick Up Child From Facility

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Other Children Living at Home

Name: _____ Date of Birth: _____
Surname if not same as child enrolled Day/Month/Year

Name: _____ Date of Birth: _____
Surname if not same as child enrolled Day/Month/Year

Has Child Had Previous Experience Away From Home? (Daycare, Preschool, etc)

_____ Yes _____ No Where: _____

Where there any special problems? _____

Special words used for toileting? _____

If child has any known Health problems, indicate what they are:

_____ On Medication _____
_____ Allergies _____
_____ Vision and/or hearing problems _____
_____ Special Diet _____

Please give instructions (if required) on any of the items you have ticked:

_____
_____

Indicate any accident, illness or medical disabilities your child has had (give dates):

_____
_____

Comments or instructions for caregiver(Tick appropriate ones)

[ ] Medication [ ] Allergy
[ ] Therapeutic Diet (For reasons of Health, Religion, Ethnicity:_____

_____
_____

[ ] special instructions from parent or health care professional: (attach documentation)

_____

_____

[ ] Custody order [ ] Yes [ ] No

Indicate Illness or Medical Disabilities your child has (Give dates):

BASIC IMMUNIZATION SCHEDULE – VANCOUVER ISLAND HEALTH AUTHORITY								
	1ST VISIT @ 2 MTHS	2ND VISIT 2 MO. AFTER	3RD VISIT 2MO. AFTER 2ND	4TH VISIT AFTER 12 MO. OF AGE	5TH VISIT 12 MO. AFTER 3RD.	5-6 YEARS	GRADE 6	GRAD 9
INDICATE DATE IMMUNIZATIONS RECEIVED →								
Diphtheria	*	*	*		*	*		*
Pertussis	*	*	*		*	*		*
Tetanus	*	*	*		*	*		*
poliomyelitis	*	*	*		*	*		
HIB (1)	*	*	*		*			
Hepatitus B	* (2)	* (2)	* (2)				**(3)	
Pneumococcal Conjugate	*(4)	*(4)	*(4)		*(4)			
Measles/Mumps/Rubella				*	*			
Meningococcal C Conjugate	5			*(5)	*		*(7)	*(7)
Varicella (chickenpox)				*(8)		*(9)	*(9)	

1. HIB PROTECTS AGAINS HAEMOPHILUS INFLUENZAE B WHICH MAY CAUSE MENINGITIS
2. HEPATITIS B IMMUNIZATION PROGRMA FOR CHILDREN BORN ON OR AFTER JANUARY 1, 2001
3. GRADE 6 HEPATITIS B FOR CHILDREN WHO WERE NOT PREVIOUSLY IMMUNIZED
4. PNEUMOCOCCAL CONJUGATE FOR CHILDRNE BORN ON OR AFTER JULY 1, 2003
5. MENINGOCOCCAL C CONJUGATE:
   - FOR CHILDRNE BORN ON OR AFTER APRIL 1, 2005 ONE DOSE AT 2 MONTHS OF AGE AND ONE DOSE AT 1 YEAR OF AGE
   - FOR CHILDREN BORN ON OR AFTER JULY 1, 2002 ONE DOSE AT 12 MONTHS
6. ALL FIRST NATIONS CHILDREN, AGES 2- 59 MTHS, SHOULD RECEIVE AN AGE-APPROPRIATE SERIES OF PNEUMOCOCCAL CONGUGATE VACCINE
7. GRADE 6 AND GRADE 9 MENINGOCCAL C: - FOR CHILDREN WHO WERE NOT PREVIOUSLY IMMUNIZED
8. VARICELLA (CHICKENPOX) FOR CHILDREN, BORN ON OR AFTER JANUARY 1, 2004, WHO HAVE NOT HAD CHICKENPOX DISEASE, SHINGLES, OR PREVIOUS DOSE OF VARICELLA VACCINE.
9. VARICELLA (CHICKENPOX) FOR CHILDREN WHO HAVE NOT HAD CHICKENPOX DISEASE, SHINGLES OR PREVIOUS DOSE OF VARICELLA VACCINE.

I hereby give my consent for a staff member to call a medical practitioner or ambulance for my child in case of an accident or illness, if I cannot be reached immediately.

Parent/Guardians Signature: _____Dated: _____

Day/Month/Year