CHILD'S NAME: _____

## Summerside Montessori Children's Studio Child Care Facility

## CHILD INFORMATION ENROLLMENT FORM

**Check off The Program The Child Is Being Enrolled In:**

**FULL DAY MONTESSORI - FULL TIME/PART TIME**

- ☐ **Full Day Montessori - 5 days a week - Monday to Friday - 7:15 AM to 5:15 pm - $1,387.00 per month**
- ☐ **Full Day Montessori - 3 days a week - Wednesday, Thursday & Friday - 7:15 AM to 5:15 pm - $832.00 per month**
- ☐ **Full Day Montessori - 2 days a week - Monday & Tuesday - 7:15 AM to 5:15 pm - $555.00 per month**

**MORNING MONTESSORI - FULL TIME/PART TIME**

- ☐ **Morning Montessori - 5 days a week - Monday to Friday 7:15 AM to 12:00 pm - $694.00 per month**
- ☐ **Morning Montessori - 3 days a week - Wednesday, Thursday & Friday 7:15 AM to 12:00 pm - $416.00 per month**
- ☐ **Morning Montessori - 2 days a week - Monday & Tuesday 7:15 AM to 12:00 pm - $278.00 per month**

**AFTERNOON MONTESSORI - FULL TIME/PART TIME**

- ☐ **Afternoon Montessori - 5 days a week - Monday to Friday - 12:30 pm to 5:15 pm - $694.00 per month**
- ☐ **Afternoon Montessori - 3 days a week - Wednesday, Thursday & Friday - 12:30 pm to 5:15 pm - $416.00 per month**
- ☐ **Afternoon Montessori - 2 days a week - Monday & Tuesday - 12:30 pm to 5:15 pm - $278.00 per month**

**PLEASE COMPLETE THE SECTIONS AND ANSWER THE QUESTIONS LISTED BELOW SO THAT WE HAVE CLEAR INFORMATION ABOUT YOUR FAMILY AND THE NEEDS OF YOUR CHILD. THIS INFORMATION WILL BE MADE AVAILABLE TO THE EDUCATORS WHO WORK TO SUPPORT YOUR CHILD AND FAMILY.**

**This form to be completed at time of enrollment and annually thereafter.**

**CHILD'S NAME:** _____

## Personal Information

| | | |
|---|---|---|
| CHILD'S DATE OF BIRTH: | GENDER: | INITIAL STARTING DATE: |
| ADDRESS: | | POSTAL CODE: |
| | | PHONE: ( ) |
| PARENT OR GUARDIAN: | | PARENT OR GUARDIAN: |
| ADDRESS {IF DIFFERENT FROM ABOVE} | | ADDRESS {IF DIFFERENT FROM ABOVE} |
| PHONE: EMAIL: | | PHONE: EMAIL: |
| WORK ADDRESS/ALTERNATE LOCATION: | | WORK ADDRESS/ALTERNATE LOCATION: |
| PHONE {INCLUDE LOCAL}: | | PHONE {INCLUDE LOCAL}: |
| CELLULAR: | | CELLULAR: |
| HOURS AT THIS LOCATION: | | HOURS AT THIS LOCATION: |

## Emergency Health Information

| | | | |
|---|---|---|---|
| HEALTH CARD NUMBER: | | | |
| FAMILY DOCTOR/CLINIC NAME: | | FAMILY DENTIST/CLINIC NAME: | |
| ADDRESS: | PHONE: | ADDRESS: | PHONE: |

## Consent for Emergency Care

I authorize the staff at the child care centre to call 911 in the case of an injury, accident or illness if my child(ren) requires medical attention. Staff will also provide first aid and contact the parent.

| | |
|---|---|
| SIGNATURE OF PARENT/GUARDIAN: | |
| DIRECTOR: DATE: | |

## Person(s) Authorized to pick up Child

**(other than parent/guardian listed above)**

| | | |
|---|---|---|
| NAME: | RELATIONSHIP: | PHONE: |
| NAME: | RELATIONSHIP: | PHONE: |
| NAME: | RELATIONSHIP: | PHONE: |
| NAME: | RELATIONSHIP: | PHONE: |

## Emotional

HOW DOES YOUR CHILD REACT WHEN LEFT WITH UNFAMILIAR PEOPLE AND/OR IN UNFAMILIAR SITUATIONS?

**CHILD'S NAME:** _____

| DOES YOUR CHILD HAVE ANY PARTICULAR FEARS? PLEASE DESCRIBE: |
|---|
| WHAT SUGGESTIONS DO YOU HAVE THAT WOULD HELP STAFF MAKE YOUR CHILD'S TRANSITION INTO THIS PROGRAM EASIER? |

## Family and General Household Information

| NAME OF ENGLISH SPEAKING PERSON {IF NEEDED} | PHONE: |
|---|---|

## Any Other Comments

| |
|---|
| |
| |
| |
| |
| |
| |

## Signature of Parent or Guardian Providing Information

| SIGNATURE: | PRINT NAME: | DATE: |
|---|---|---|

**NOTE: This information may be reviewed by child care licensing staff during program inspections.**

## Facility Use Only

| **Staff person reviewing family's documents:** | | |
|---|---|---|
| SIGNATURE: | PRINT NAME: | DATE: |
| CHILD'S WITHDRAWAL DATE: | REASON FOR WITHDRAWAL: | |

**CHILD'S NAME:** _____

## Eating and Nutrition

LIST YOUR CHILD'S FAVOURITE FOOD:

LIST ANY DISLIKED FOOD:

PLEASE DESCRIBE ANY PARTICULAR EATING PATTERNS:

ARE THERE ANY RELIGIOUS OR ETHNIC OBSERVANCES RELATED TO FOODS:

## Sleeping

| | | |
|---|---|---|
| NAP TIME: | HOW LONG TO SETTLE: | TIME OF WAKING: |
| BED TIME: | HOW LONG TO SETTLE: | TIME OF WAKING: |

IS YOUR CHILD A DEEP SLEEPER , OR DOES (S)HE AWAKEN EASILY?

DOES YOUR CHILD TAKE A FAVOURITE COMFORTER {E.G., BLANKET OR TOY} TO BED? _____ YES _____ NO

IF YES, PLEASE DESCRIBE AND TELL US IF IT IS "NAMED":

WHAT IS YOUR CHILD'S MOOD UPON WAKING?

## Toileting

IS YOUR CHILD TOILET-TRAINED? _____ YES _____ NO _____ PARTIALLY

PLEASE INDICATE YOUR CHILD'S FREQUENCY OR PATTERNS FOR BOWEL MOVEMENTS:

DESCRIBE ASSISTANCE NEEDED FOR TOILETING:

WHAT "SPECIAL " WORD DOES YOUR CHILD USE FOR: URINATION_____ BOWEL MOVEMENTS_____

**CHILD'S NAME:** _____

## Additional Child History

INJURY(S), ILLNESS(ES) OR OPERATIONS YOUR CHILD HAS HAD AND INCLUDE THE DATE(S).

a) Please describe any concerns/issues regarding your child's health (seizures, asthma, vision, hearing, etc.)

b) Please describe any concerns you may have regarding your child's development (i.e. , behaviour, vision, hearing, speech, language, mobility, etc.)

c) Describe any specific care instruction regarding a) and/or b)

OTHER HEALTH CARE PROFESSIONALS INVOLVED IN YOUR CHILD'S LIFE, E.G., OCCUPATIONAL THERAPIST/PHYSICAL THERAPIST:

## Group Experiences

WHAT IS/ARE YOUR CHILD'S FAVOURITE TOY(S) /ACTIVITIES:

HAS YOUR CHILD HAD PREVIOUS PLAY GROUP EXPERIENCE? _____ YES _____NO

IF YES, HOW DID HE/SHE ADAPT?

HOW DOES YOUR CHILD BEHAVE TOWARD OTHER CHILDREN {E.G., SEEKS OTHERS OUT, FEELS SHY}:

## Family and General Household Information

PLEASE LIST THE NAMES OF THE SIGNIFICANT PEOPLE IN YOUR CHILD'S LIFE {E.G., SIBLINGS, GRANDPARENTS, ETC.}:

PLEASE DESCRIBE THE GUIDANCE AND DISCIPLINE METHODS USED AT HOME.:

**CHILD'S NAME:** _____

| PRIMARY LANGUAGE SPOKEN IN THE HOME: | OTHER LANGUAGES: |
|---|---|

## Person(s) NOT Authorized to Pick Up Your Child

| NAME: | RELATIONSHIP: | PHONE: |
|---|---|---|
| NAME: | RELATIONSHIP: | PHONE: |

## Custody Agreement:

_____ YES _____ NO

IF YES, SUPPLY A COPY OF THE CUSTODY ORDER TO THE DIRECTOR

**Be sure to update us in writing if any of your emergency contacts change.**

## ALTERNATE PERSON(S) TO CALL AND PICK UP CHILD IN CASE OF EMERGENCY

| NAME: | RELATIONSHIP: | PHONE: |
|---|---|---|
| NAME: | RELATIONSHIP: | PHONE: |
| NAME: | RELATIONSHIP: | PHONE: |
| NAME: | RELATIONSHIP: | PHONE: |
| NAME: | RELATIONSHIP: | PHONE: |

## Child's Immunization Status

**IS YOUR CHILD UP TO DATE ON IMMUNIZATIONS?** _____ **YES** _____ **NO** _____ **NOT IMMUNIZED**

**COMMENTS:**

## Health Information

REGULAR MEDICATION(S) AND REASONS FOR (PLEASE LIST):

ALLERGIES AND TREATMENT OF (PLEASE LIST):

**CHILD'S NAME:** _____

PLEASE WRITE ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO BE AWARE OF BELOW:

**CHILD'S NAME:** _____

**I understand Summerside Montessori Children's Studio will retain this information in my child's file to support their participation in the child care program.**

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

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