GLENDALE EARLY LEARNING AND CHILD CARE CENTRE REGISTRATION

Date of Admission _____ Date of Withdrawal _____

Name of Child_____

Surname Given Names

Male _____ Female _____

Address _____ Telephone_____

_____ Postal Code_____

Date of Birth Day____ Month ____Year ____

Family Physician's Name _____ Address_____

Phone Number _____

Name of Father _____ Home Address (if different from child's)

_____

Occupation _____ Address _____

Telephone _____

Name of Mother _____ Home Address (if different from child's)

_____

Occupation _____ Address _____

Telephone _____

Number of Children in Family _____ Ages _____

Name of person willing to assume responsibility for child (in case of parent's absence) in case of emergency, accident or illness during school hours:

Name _____ Address _____

Relationship _____ Telephone _____

Child's previous history of communicable diseases, conditions requiring medical attention, immunization and/or written objection or any symptoms indicative of ill health:

_____

_____

Is child immunized: _____ yes, _____ no

If yes, please fill out Niagara Region Child Care Information form.

If no, please fill out Statement of Conscience or Religious Belief form.

Any special requirements with sleeping, toilet training, eating, etc.: _____

_____

Care is required from _____a.m. to _____ p.m.

Child will come to school with _____

Child will be released to_____

Signature of Parent _____ Signature of Supervisor _____