Keating Out-of-School Care

Child Care Registration Package

FAMILY INFORMATION

CHILD'S LEGAL NAME: ______________________ NAME CHILD GOES BY: ______________
SURNAME GIVEN MIDDLE

DATE OF BIRTH: ______________ GENDER: ____________ PRONOUNS: ____________
YYYY / MM / DD

PRIMARY LANGUAGE: ______________________ SECONDARY LANGUAGE: ______________

PARENT/GUARDIAN #1 NAME: ______________________ PRONOUNS: ____________

ADDRESS: ______________________ CELL PHONE: ____________

CITY: ____________ POSTAL CODE: ____________ HOME PHONE: ____________

EMPLOYER: ______________________ WORK PHONE: ____________

EMAIL ADDRESS: ______________________

PARENT/GUARDIAN #2 NAME: ______________________ PRONOUNS: ____________

ADDRESS: ______________________ CELL PHONE: ____________

CITY: ____________ POSTAL CODE: ____________ HOME PHONE: ____________

EMPLOYER: ______________________ WORK PHONE: ____________

EMAIL ADDRESS: ______________________

NAMES OF OTHER CHILDREN LIVING AT HOME:

NAME: ______________________ DATE OF BIRTH: ____________

NAME: ______________________ DATE OF BIRTH: ____________

NAME: ______________________ DATE OF BIRTH: ____________

ARE THERE CUSTODY RESTRICTIONS? YES ☐ NO ☐
IF YES, PLEASE ATTACH A COURT ORDER AND STATE GENERAL CONDITIONS:

____

____

____

NAMES OF PERSONS **NOT** PERMITTED ACCESS TO CHILD:

NAME: ______________________

NAME: ______________________

EMERGENCY CONTACTS

Note: Must be different from parent/guardian(s).

NAME: ______________________________ RELATIONSHIP: ______________

CELL PHONE: ______________ WORK PHONE: ______________ HOME PHONE: ______________

NAME: ______________________________ RELATIONSHIP: ______________

CELL PHONE: ______________ WORK PHONE: ______________ HOME PHONE: ______________

NAME: ______________________________ RELATIONSHIP: ______________

CELL PHONE: ______________ WORK PHONE: ______________ HOME PHONE: ______________

PERSONS AUTHORIZED TO PICK UP CHILD FROM CARE

☐ Check to include emergency contacts

Note: Staff MUST BE NOTIFIED IN ADVANCE when a person authorized below is picking up your child.

NAME: ____________________ RELATIONSHIP: ______________ PHONE: ______________

NAME: ____________________ RELATIONSHIP: ______________ PHONE: ______________

NAME: ____________________ RELATIONSHIP: ______________ PHONE: ______________

NAME: ____________________ RELATIONSHIP: ______________ PHONE: ______________

NAME: ____________________ RELATIONSHIP: ______________ PHONE: ______________

NAME: ____________________ RELATIONSHIP: ______________ PHONE: ______________

NAME: ____________________ RELATIONSHIP: ______________ PHONE: ______________

NAME: ____________________ RELATIONSHIP: ______________ PHONE: ______________

NAME: ____________________ RELATIONSHIP: ______________ PHONE: ______________

NAME: ____________________ RELATIONSHIP: ______________ PHONE: ______________

PROGRAM INFORMATION

HAS YOUR CHILD HAD EXPERIENCE AWAY FROM HOME, SUCH AS A DAYCARE/PRESCHOOL?

☐ YES ☐ NO WHERE: ______________________ DURATION: ____________________

ARE THERE ANY CIRCUMSTANCES THAT YOU FEEL WE SHOULD BE AWARE OF?

____

____

____

HOW DID YOU LEARN OF KEATING OUT-OF-SCHOOL CARE? PLEASE CHECK ALL THAT APPLY:

☐ KOSC WEBSITE/NEWSLETTER ☐ SCHOOL/PAC WEBSITE ☐ FAMILY/FRIEND ☐ SCHOOL

☐ OTHER: ____

SWIMMING LEVELS

On field trips, KOSC will sometimes go to pools or lakes that permit swimming. Children are given coloured wristbands according to their swimming ability. In order to make it as safe as possible, please indicate the current water level you feel comfortable allowing your child to go to:

☐ WAIST LEVEL (ORANGE)	☐ SHOULDER LEVEL (GREEN)	☐ OVER-THE-HEAD LEVEL (PINK)	☐ NO SWIMMING

Note: Children six and under will be required to wear a life jacket at most pools. At lakes, the furthest we allow children to swim is Shoulder Level. Children are not allowed to wade deeper than their knees at any ocean beach.

PAYMENT

☐ 100% by Parent/Guardian(s)

☐ Affordable Child Care Benefit (amount if known): ______________

☐ Other (please specify): ____

Note: A current Pre-Authorized Debit agreement (PAD) must be completed to finalize registration.

HEATH/MEDICAL

BC MEDICAL NUMBER: ______________________________

FAMILY DOCTOR/CLINIC: ______________________ PHONE NUMBER: ______________

Note: Island Health Authority requires us to have a doctor on file for all children in care. If you do not have a family doctor, please provide the name of the medical clinic that you would go to if your child needs care.

HAS YOUR CHILD HAD ANY SERIOUS ILLNESS OR HEALTH PROBLEMS THAT WE SHOULD BE AWARE OF?	☐ YES	☐ NO
DOES YOUR CHILD HAVE ANY ALLERGIES OR FOOD RESTRICTIONS?	☐ YES	☐ NO
DOES YOUR CHILD REQUIRE ANY MEDICATION?	☐ YES	☐ NO
HAS YOUR CHILD HAD ANY TOILETING ACCIDENTS IN THE PAST 6 MONTHS?	☐ YES	☐ NO
DOES YOUR CHILD HAVE ANY DISABILITIES THAT WE SHOULD BE AWARE OF?	☐ YES	☐ NO
DOES YOUR CHILD HAVE A SPECIAL NEEDS SUPPORT WORKER?	☐ YES	☐ NO

If you answered "yes" to any of the above, please complete a Health Plan found on Page 5.

PLEASE LIST ANY SPECIAL DIETARY RESTRICTIONS THAT WE SHOULD BE AWARE OF:

IS THERE ANY FURTHER INFORMATION ABOUT YOUR CHILD THAT WOULD BE HELPFUL FOR THE STAFF TO KNOW IN ORDER FOR THEM TO ENJOY OUR PROGRAM TO ITS FULLEST?

PLEASE FILL IN THE DATES THAT YOUR CHILD RECEIVED THEIR IMMUNIZATIONS:

First visit – two months of age (YYYY/MM/DD): ______________ ☐ Diphtheria ☐ Pertussis ☐ Tetanus ☐ Polio ☐ Hepatitis B ☐ Haemophilus Influenza Type b (hib) ☐ Pneumococcal Conjugate ☐ Meningococcal C Conjugate
Second visit – two months after first visit (YYYY/MM/DD): ______________ ☐ Diphtheria ☐ Pertussis ☐ Tetanus ☐ Polio ☐ Hepatitis B ☐ Haemophilus Influenza Type b (hib) ☐ Pneumococcal Conjugate
Third visit – two months after second visit (YYYY/MM/DD): ______________ ☐ Diphtheria ☐ Pertussis ☐ Tetanus ☐ Polio ☐ Hepatitis B ☐ Haemophilus Influenza Type b (hib)
Fourth visit – 12 months of age (YYYY/MM/DD): ______________ ☐ Measles ☐ Mumps ☐ Rubella ☐ Meningococcal C Conjugate ☐ Varicella (chicken pox)
Fifth visit – 12 months after third visit (YYYY/MM/DD): ______________ ☐ Diphtheria ☐ Pertussis ☐ Tetanus ☐ Polio ☐ Haemophilus Influenza Type b (hib) ☐ Measles, Mumps, Rubella ☐ Pneumococcal Conjugate
4 to 6 years of age (YYYY/MM/DD): ______________ ☐ Diphtheria ☐ Pertussis ☐ Tetanus ☐ Polio ☐ Varicella (chicken pox)

Note: Island Health Authority requires these dates to be on file. Photocopies of a "Health Passport" or a printout of immunization records are acceptable.

HEALTH AND CARE PLAN (IF APPLICABLE)

Please list and describe the health concern for your child:

Please list the steps to take to manage the health concern:

1.
2.
3.
4.
5.

What medications (if any) and in what order do they need to be taken:

Please add any additional information:

Once completed, the Program Manager will review this form with you.

HEALTH AND CARE PLAN REVIEW DOCUMENTATION

After a discussion between KOSC and the child's parent, the Health Plan will be documented below. Both parties must sign and date the documentation below. Any further changes made to the plan, and the manner in which the staff will assist, must be further documented and dated. The Health Plan must be reviewed annually by the parent.

Parent's Signature	Date	Program Manager's Signature	Date

PERMISSIONS

I give permission for my child to go on field trips arranged by KOSC, and I understand that I will be informed in advance. ☐ YES ☐ NO

I give permission for my child's picture to be taken in the program setting for use in the daycare. ☐ YES ☐ NO

I have received a copy of the parent agreement and I understand and accept these conditions. ☐ YES ☐ NO

I authorize the staff at KOSC to call a physician, take my child to the nearest emergency centre, or summon an ambulance for emergency medical aid should the person(s) in attendance feel such services are required and I cannot be contacted by phone. If such an emergency should arise, I shall be notified as soon as possible. I agree that any cost incurred for such services shall be the sole responsibility of myself.

Parent's Signature ______________________________ Date ____________________

I certify that the information in this form is correct and that I am the legal guardian of ____________________

Parent's Signature ______________________________ Date ____________________

I accept legal responsibility of payment of all accounts rendered to this family by KOSC.

Parent's Signature ______________________________ Date ____________________

I have read and understood the Parent Handbook, Parent Agreement, and Registration Information Sheet.

Parent's Signature ______________________________ Date ____________________

In the interest of your child, please notify us in writing of ANY CHANGES to the information in this package.

Information supplied on this form is for the custody and control of Keating Out-of-School Care. Collecting such information is required by the Child Care Regulations, Community Care and Assisted Living Act.

PLEASE RETURN THE FOLLOWING TO KOSC TO ENSURE REGISTRATION IS COMPLETED AND PROCESSED PROMPTLY:

- ☐ Registration Package (completed and signed in full)
- ☐ Emergency Permission Card (available from KOSC office)
- ☐ Pre-Authorized Debit Form (with void cheque or official bank account documentation). Please note membership fee will be debited from account on 15th of month following first use of services
- ☐ Photo of Child
- ☐ Care Required Form (page 7)

Please refer to our website for further information regarding policies and procedures: www.keatingoutofschoolcare.com

CARE REQUIRED FORM

SEPTEMBER 2024 – JUNE 2025

Child's Name: ______________________________

Child's Grade in September 2024: ______________________________

Child's Teacher (if known) ______________________________

BEFORE SCHOOL CARE (7:00 am – 8:40 am)

☐ Full-Time Mornings

☐ Part-Time Mornings: Please place an "X" on the days you require: M T W TH F

If KOSC is unable to match my part-time request, I am willing to go full-time: ☐ YES ☐ NO

If you are flexible on the day(s) of your part-time request, please tell us how as it may increase your ability to match up with another family:

____

____

AFTER SCHOOL CARE (2:45 pm – 6:00 pm)

☐ Full-Time Afternoons

☐ Part-Time Afternoons: Please place an "X" on the days you require: M T W TH F

If KOSC is unable to match my part-time request, I am willing to go full-time: ☐ YES ☐ NO

If you are flexible on the day(s) of your part-time request, please tell us how as it may increase your ability to match up with another family:

____

____

DROP-IN CARE

☐ I am interested in utilizing KOSC on a drop-in basis if space allows. Please see Program Manager for further details.

FOR OFFICE USE

STAFF INITIALS: __________ DATE/TIME RECEIVED: __________ PROGRAM START DATE: __________