



Kiddo House Child Care

CHILD'S START DATE: ____/____/____ SEX: M ____ F ____
YY MM DD

DATE OF BIRTH: ____/____/____ NAME OF CHILD: _____
YY MM DD (Surname) (Given Names) (Also Known As)

Name the child responds to: _____

Address: _____

Postal code: _____ Phone: _____

Person(s) with 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) authorized to pick up the child and be contacted in case of emergency. These people should be available during hours of care. (include mother / father / guardian):

Name: _____ Relationship to child: _____

Work phone: _____ Cell phone: _____

Name: _____ Relationship to child: _____

Work phone: _____ Cell phone: _____

Name: _____ Relationship to child: _____

Work phone: _____ Cell phone: _____

Name: _____ Relationship to child: _____

Work phone: _____ Cell phone: _____

If appropriate, list an English speaking contact:

Name: _____ Phone: _____

Has the child previously attended davcare/preschool?

YES/NO Comments: _____

Comments/instructions to help us care for your child. (Please feel free to add additional pages.):

Toileting/Diapering (special words): _____

Rest time (special comfort – toy/blanket) _____

Eating/Mealtime (include food likes/dislikes):

Fears: _____

Please tell us anything else you think will help us provide an enriching experience for your child:

HEALTH INFORMATION:

Health professionals involved with your child (other than doctor and dentist):

NAME	PROFESSION/AGENCY	PHONE
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_____	_____	_____
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_____	_____	_____
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_____	_____	_____
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Does your child have: A medical condition/concern? YES/NO

If yes, please provide further information: _____

Allergies? YES/NO

If yes, please provide further information: _____

Asthma? YES/NO

If yes, please provide further information: _____

Has your child had a seizure in the past year? YES/NO

If yes, please provide further information: _____

Does your child require a special diet related to a medical condition? YES/NO

If yes, please provide further information: _____

Food sensitivities? YES/NO

If yes, please provide further information: _____

List all prescription and “over the counter” medications your child receives:

Medication	Times Given	Reason for Medication

You may be asked to complete additional forms if you answered yes to any of the above.
 The above health information may be made available to the staff of Vancouver Coastal Health.

Custody Agreement: YES N/A Provided to Facility: YES NO N/A

Photocopy of Immunization Records Provided to the Facility: YES NO

Parent/Guardian: _____ / _____ / _____

Name Signature YY MM DD

Staff/Caregiver: _____ / _____ / _____

Name Signature YY MM DD

Office Use Only

Date child leaves the facility: _____ / _____ / _____

YY MM DD