Maison Kinder – Registration Form

CHILD'S STARTING DATE: _____/_____/ _____
YY MM DD

SEX: M_____F _____

DATE OF BIRTH: ____/ _____/ _____
YY MM DD

NAME OF CHILD: _____
(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:_____Email: _____

Name:_____Home phone:_____Cell phone: _____

Work phone:_____Days/hours of work:_____Email: _____

Emergency Contact:_____Cell Phone:_____Phone: _____

Emergency Contact:_____Cell Phone: _____Phone:_____

Person(s) authorized to pick up the child:

Name:_____Relationship to child:_____

Home phone:_____Work phone:_____Cell phone:_____

Name:_____Relationship to child: _____

Home phone: _____Work phone:_____Cell phone: _____

Name:_____Relationship to child: _____

Home phone:_____Work phone:_____Cell phone: _____

Name: _____Relationship to child: _____

Home phone: _____Work phone: _____Cell phone: _____

Has the child previously attended daycare/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): _____

Temperament: _____

Favorite things: _____

Fears: _____

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

_____

_____

HEALTH INFORMATION

Child's Medical Card Number: _____

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 nonprescription (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.

Information Provided By:

DATE:_____/_____/_____ _____ _____

YY MM DD **Print Name** **Signature**

Information Received By:

DATE:_____/_____/_____ _____ _____

YY MM DD **Print Name** **Signature**

This health information may be made available to the staff of Maison Kinder.

THANK YOU!