Tri-City Community Montessori Preschool

275 April Road * Port Moody, BC * 604-461-7505

REGISTRATION FORM

TODAY'S DATE: DATE OF ENROLLMENT:

CHILD'S FIRST NAME: CHILD'S LAST NAME:

PERSONAL INFORMATION

STREET ADDRESS

/ / DATE OF BIRTH (MM/DD/YYYY)

MALE ( ) ( ) FEMALE

CITY AND POSTAL CODE

FIRST AND LAST NAME OF PARENT/GUARDIAN CONTACT PHONE NUMBER

FIRST AND LAST NAME OF PARENT/GUARDIAN CONTACT PHONE NUMBER

ALTERNATE PERSONS AUTHORIZED TO PICK UP CHILD (other than parent/guardian)

FULL NAME RELATIONSHIP TO CHILD PHONE NUMBER

FULL NAME RELATIONSHIP TO CHILD PHONE NUMBER

FULL NAME RELATIONSHIP TO CHILD PHONE NUMBER

PERSON(S) NOT AUTHORIZED TO PICK UP CHILD

FULL NAME RELATIONSHIP TO CHILD PHONE NUMBER

FULL NAME RELATIONSHIP TO CHILD PHONE NUMBER

CUSTODY AGREEMENT

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

YES ( ) ( ) NO

EMERGENCY PERSONS AUTHORIZED TO PICK-UP CHILD (In case of emergency)

FULL NAME RELATIONSHIP TO CHILD PHONE NUMBER

FULL NAME RELATIONSHIP TO CHILD PHONE NUMBER

CHILD'S EMERGENCY HEALTH INFORMATION

CARE CARD NUMBER: _____

FAMILY DOCTOR: _____

FULL NAME PHONE NUMBER

FAMILY DENTIST: _____

FULL NAME PHONE NUMBER

CONSENT FOR EMERGENCY CARE

I authorize the staff at the Preschool Centre to call a medical practitioner or ambulance in case of accident or illness of my child(ren), if the parent cannot immediately be reached.

_____ _____

SIGNATURE OF PARENT/GUARDIAN SIGNATURE OF LICENSEE

CHILD'S IMMUNIZATION STATUS (Fill out dates, or attach records)

	Diphtheria	Pertussis	Tetanus	Polio	Pneumo	Hib	Hep B	MMR
1								
2								
3								
4								
5								

ALLERGIES OR OTHER HEALTH INFORMATION

PLEASE LIST ANY ALERGIES AND TREATMENTS:

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

PLEASE LIST ANY KNOWN HEALTH ISSUES OR COMMUNICABLE DISEASES CHILD HAS HAD:

SIGNATURE OF PARENT (VERIFYING INFORMATION IS CORRECT) SIGNATURE OF LICENSEE (CHECKING FORMS ARE COMPLETE)