101 Spruce Street, Fort McMurray, AB., T9K 1E2 daycare@fmalliance.ca

Telephone 780-791-4482 or 780-791-2434 Fax 780-790-1869

*The personal information that you provide on this form is being collected and administered under the Protection of Privacy Act of* ***Alberta****. It will be used by Children's Programs for the purpose of providing: security access information for the release of children into the custody of guardians, updated immunization records and medical history for the individual child, emergency medical information, emergency first aid authorization and outings and walks authorization for the individual child. This form also ensures awareness of the program's behaviour policy. The information will be protected in compliance with the provisions of the Freedom of Information and Protection of Privacy Act of* ***Alberta****. The information will be retained by this organization for a period of five years, after which it will be destroyed in a secure manner. If you have any questions about the collection and use of this personal information, please contact Church Administrator at admin@fmalliance.ca or 780-791-2434.*

| **CHILD'S PERSONAL INFORMATION** | | DATE OF APPLICATION (YYYY-MM-DD) |
|---|---|---|
| LAST NAME | FIRST NAME | MIDDLE NAME |
| PREFERRED FIRST NAME | DATE OF BIRTH (YYYY-MM-DD) | |
| STREET | CITY/TOWN | PROVINCE |
| POSTAL CODE | HOME PHONE NUMBER | |

| **PARENT OR LEGAL GUARDIAN INFORMATION** (LIST ONLY THOSE PERSONS WITH ACCESS TO THE CHILD) | | | |
|---|---|---|---|
| **1.** LAST NAME | FIRST NAME | MIDDLE NAME | |
| RELATIONSHIP TO CHILD | STUDENT PROGRAM (IF APPLICABLE) | STUDENT ID NUMBER (IF APPLICABLE) | |
| **HOME ADDRESS** ◻ SAME AS CHILD OR | | | |
| STREET | CITY/TOWN | PROVINCE | |
| POSTAL CODE | HOME PHONE NUMBER | | |
| **WORK INFORMATION** (FOR CONTACT DURING WORKING HOURS) | | | |
| COMPANY NAME | STREET | | |
| CITY/TOWN | PROVINCE | POSTAL CODE | WORK PHONE NUMBER |

| **2.** LAST NAME | FIRST NAME | MIDDLE NAME |
|---|---|---|
| RELATIONSHIP TO CHILD | STUDENT PROGRAM (IF APPLICABLE) | STUDENT ID NUMBER (IF APPLICABLE) |
| **HOME ADDRESS** ◻ SAME AS CHILD OR | | |
| STREET | CITY/TOWN | PROVINCE |
| POSTAL CODE | HOME PHONE NUMBER | |
| **WORK ADDRESS** | | |
| STREET | CITY/TOWN | PROVINCE |
| POSTAL CODE | WORK PHONE NUMBER | |

| **OTHER INFORMATION** |
|---|
| Are there any special custody arrangements we should be aware of? If so, please provide the necessary information and copy of relevant documentation. |
| |

| **BILLING INFORMATION** (BILL TO:) | | | |
|---|---|---|---|
| LEGAL LAST NAME | LEGAL FIRST NAME | | MIDDLE NAME |
| MAIDEN NAME (IF APPLICABLE) | STREET | | CITY/TOWN |
| PROVINCE | POSTAL CODE | CITIZENSHIP | DATE OF BIRTH (YYYY-MM-DD) |

| **EMERGENCY CONTACT INFORMATION** | |
|---|---|
| Please provide the names of two adults (other than those previously listed) who may be contacted in case of emergency. | |
| **1.** NAME | HOME PHONE NUMBER |
| ADDRESS | WORK PHONE NUMBER |
| **2.** NAME | HOME PHONE NUMBER |
| ADDRESS | WORK PHONE NUMBER |

| **CONSENT FOR RELEASE OF CHILD IN CARE** | | |
|---|---|---|
| Including yourself, please list all persons who may be required to pick up your child from care. **Please note that photo identification may be required prior to the release of the child.** | | |
| NAME | | |
| NAME | | |
| NAME | | |
| I, | | authorize AFC(The Alliance Family Center) to release my child |
| | ***Parent****/Guardian* | |
| | | into the custody of the persons named above. I understand it is my responsibility to inform the Children's Program of any changes to this list. |
| *Child's name in full* | | |
| SIGNATURE | | DATE |

| **HEALTH INFORMATION** | | | |
|---|---|---|---|
| FAMILY PHYSICIAN | | PHONE NUMBER | |
| ADDRESS | | CHILD'S HEALTH CARE NUMBER | |
| **IMMUNIZATION HISTORY –** Please note the dates <u>or</u> attach a copy of the child's immunization record | | | Attached ☐ |
| | DATE | | DATE |
| DPT/Polio/HIB (2 months) | | Measles/Mumps/Rubella (12 months) | |
| DPT/Polio/HIB (4 months) | | DPT/Polio/HIB (18 months) | |
| DPT/HIB (6 months) | | DCP/Polio (4-6 years) | |
| If you have chosen **NOT** to immunize your child please discuss this with the Coordinator. | | | |

| **IMMUNIZATION CERTIFICATION** | |
|---|---|
| I hereby certify that my child's immunizations are up to date according to the above or attached schedule. | |
| SIGNATURE | DATE |

| **HEALTH HISTORY** CHOOSE ☒ | | | | |
|---|---|---|---|---|
| Does your child have any health problems which we should be aware of? (i.e. allergies, asthma, convulsions or diabetes) | | ☐ YES | ☐ NO | If YES, give details in COMMENTS below. |
| Is your child taking any medication on a regular basis? | | ☐ YES | ☐ NO | If YES, give details in COMMENTS below. |
| Will the Children's Programs Staff/Provider be required to administer any medication? | | ☐ YES | ☐ NO | If YES, give details in COMMENTS below. |
| Is your child intolerant of any foods and/or are there any dietary problems/conditions? | | ☐ YES | ☐ NO | If YES, give details in COMMENTS below. |
| Has your child had any of the following? | | | | |
| ☐ Chicken Pox | ☐ German Measles | ☐ Whooping Cough | | ☐ Frostbite |
| ☐ Red Measles | ☐ Mumps | ☐ Scarlet Fever | | |
| COMMENTS | | | | |
| | | | | |

| **BACKGROUND INFORMATION OF CHILD AND FAMILY** |
|---|
| In order to help us make your child feel "at home", your child's caregivers would find it helpful to know a bit about his/her background, likes, dislikes, etc. |
| What is your child's typical daily routine at home (sleeping, eating, play etc.)? |
| |
| Does your child have brothers and sisters? Please list. |
| |
| Does your family have any cultural or religious restrictions or preferences (e.g. food, holiday's etc)? |
| |
| Does your child have any fears or particular dislikes? |
| |
| Do you have any concerns about your child's development (social, physical, hearing, vision etc.)? |
| |
| Is there a particular blanket or stuffed animal from home to which your child is attached? |

What are your expectations of the Center?

| VERIFICATION SIGNATURES | |
|---|---|
| **PARENT HANDBOOK/FACILITY TOUR**<br><br>Your signature below indicates that you have received a **parent handbook**, have read the information including the guiding behaviour policy, have discussed any concerns with staff, and have toured the facility. | |
| SIGNATURE | |
| **Emergency First Aid**<br><br>Your signature below indicates that you authorize the staff/provider of The Alliance Family Center to administer emergency first aid, contact the family physician or activate emergency services as required. | |
| SIGNATURE | |
| **Outings and Walks**<br><br>Your signature below indicates that you authorize outings and walks within the grounds of the child care facility, as described in the **parent handbook**. Other field trips will be authorized on a per trip basis. | |
| SIGNATURE | |
| **I hereby certify that the information in this application is true, correct and complete in every respect.** | |
| SIGNATURE | DATE |

| FOR OFFICE USE ONLY | | | | |
|---|---|---|---|---|
| START DATE | TERMINATION DATE | ATTENDANCE | ☐ FULL TIME | ☐ PART TIME |
| INFORMATION REMINDER | | | | |
| INFORMATION UPDATE | | | | |
| COMMENTS | | | | |
| | | | | |