

**MORNING GLORY FAMILY CHILD CARE CENTRE  
REGISTRATION FORM**

Name of Child: \_\_\_\_\_ Sex: M \_\_\_\_ F \_\_\_\_

Address: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Guardians: \_\_\_\_\_ Relationship: \_\_\_\_\_

Child's First Language: \_\_\_\_\_ Second: \_\_\_\_\_

Person (s) with whom the child lives: \_\_\_\_\_

Starting date: \_\_\_\_\_ Do you wish to ease the child into day care? \_\_\_\_\_

**GUARDIAN INFORMATION**

E-mail address: \_\_\_\_\_

**Mother:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Place of work: \_\_\_\_\_ Hours of work: \_\_\_\_\_

Phone #: home \_\_\_\_\_ work \_\_\_\_\_

**Father:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Place of work: \_\_\_\_\_ Hours of work: \_\_\_\_\_

Phone #: home \_\_\_\_\_ work \_\_\_\_\_

**INCASE OF EMERGENCY CONTACT: (include guardians)**

1st. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: work \_\_\_\_\_ home \_\_\_\_\_

2nd. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: work \_\_\_\_\_ home \_\_\_\_\_

3rd. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: work \_\_\_\_\_ home \_\_\_\_\_

**EMERGENCY HEALTH INFORMATION**

Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

Medical InsuranceNo.: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone #: \_\_\_\_\_

Dental Insurance No.: \_\_\_\_\_

Incuse of illness/accident what hospital would you like your child to go to? \_\_\_\_\_

\_\_\_\_\_

PERSON (S) AUTHORIZED FOR PICK-UPS:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Is there a custody agreement? If yes, give information. (attach a copy of the court order)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IMMUNIZATION RECORD (list full dates)

DPT \_\_\_\_\_

Polio \_\_\_\_\_

MMR \_\_\_\_\_

Hib-D (Meningitis) \_\_\_\_\_

School Entry (DPT,P) \_\_\_\_\_

SOCIAL INFORMATION

Names and birthdates of siblings living at home:

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Names and birthdates of others living at home:

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Name \_\_\_\_\_ Birthdate \_\_\_\_\_

List any pets at home: (include what it is and name)

\_\_\_\_\_

Has the child attended daycare/pre-school previously? Y \_\_\_\_\_ N \_\_\_\_\_

Name the facility: \_\_\_\_\_ Where: \_\_\_\_\_

HEALTH/NUTRITION INFORMATION

Was there anything unusual about the pregnancy with this child? \_\_\_\_\_

\_\_\_\_\_

Did the child require any special medical care or hospitalization at birth or during the first month after birth? \_\_\_\_\_

\_\_\_\_\_

Has this child ever been in the hospital or been seriously ill at home? Y \_\_\_\_\_ N \_\_\_\_\_

If yes, explain: \_\_\_\_\_

Has the child ever had a serious accident? Y \_\_\_\_\_ N \_\_\_\_\_ If yes, explain \_\_\_\_\_

\_\_\_\_\_

When was the last time this child saw a doctor? \_\_\_\_\_ Whom? \_\_\_\_\_  
Briefly, what was the reason? \_\_\_\_\_

Is this child on any daily medication? Y \_\_\_\_\_ N \_\_\_\_\_ If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

Is this child prone to any illnesses (ie. throat, ear, bladder,...) Y \_\_\_\_\_ N \_\_\_\_\_  
List \_\_\_\_\_ How often \_\_\_\_\_ Treatment \_\_\_\_\_  
\_\_\_\_\_

Is this child toilet trained? Y \_\_\_\_\_ N \_\_\_\_\_ At what age? \_\_\_\_\_ If this child is in the process  
of being toileted what words does the child use and explain the procedure (ie. position, routine,...)  
\_\_\_\_\_  
\_\_\_\_\_

Does this child nap? Y \_\_\_\_\_ N \_\_\_\_\_ If yes, explain (ie. time, length, where, routine...) \_\_\_\_\_  
\_\_\_\_\_

Does this child sleep through the night? Y \_\_\_\_\_ N \_\_\_\_\_ If no, explain \_\_\_\_\_  
\_\_\_\_\_

Explain your child's eating habits (ie. bottles, finger foods, solids, food dislikes, ...) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If there are any vision, hearing, speech or language problems, allergies, special diets, medication or  
health concerns please complete the Information Sheet.

\_\_\_\_\_  
Signature of Parent/Guardian \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_