





Work Email Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Parent/Guardian #2**

\_\_\_\_\_  
Last Name First Name

Full Mailing Address *(if different from the child's full mailing address on previous page):*

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

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Email Address for school correspondence:

\_\_\_\_\_

Employer: \_\_\_\_\_ Job title: \_\_\_\_\_

Work hours: \_\_\_\_\_

Work Address:

\_\_\_\_\_

Work Email Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

<b>Custody Order/Court Papers on file?</b> (please indicate N/A if not applicable)
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**3. CHILD'S EARLY HISTORY**

Was your pregnancy:  full-term                       natural                       caesarean

Were there any complications?

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If your child is adopted, please tell us at what age and under what circumstances:

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How was your baby fed?  Bottle  Breast At what age was s/he weaned? \_\_\_\_\_

Did your child crawl on hands and knees?  Yes  No At what age? \_\_\_\_\_

When did your child begin to walk? \_\_\_\_\_

When did your child begin to speak? \_\_\_\_\_

When was your child fully toilet trained (if applicable)? \_\_\_\_\_

Is your child able to separate from his/her parents? \_\_\_\_\_

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Do you have any concerns about leaving your child? \_\_\_\_\_

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Does your child allow themselves to be comforted by someone other than the parents?

Yes                       No                      If yes, how is he/she comforted?

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What is your child's first language? \_\_\_\_\_

What other languages are spoken/understood in the home? \_\_\_\_\_

Please describe any complications or extraordinary events in your child's life?

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**4. CHILD’S MEDICAL INFORMATION & HISTORY OF COMMUNICABLE DISEASE**

Ontario Health Card Number-(including version code): \_\_\_\_\_

Doctor’s Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Doctor’s Address: \_\_\_\_\_

Please circle below any illnesses that your child has had and give approximate dates of illness in the following format: **YYYY / MM / DD**. Place an ‘**X**’ next to any illness for which your child received a vaccination.

Chickenpox <i>YYYY/MM/DD</i>	Asthma <i>YYYY/MM/DD</i>	Rheumatic Fever <i>YYYY/MM/DD</i>
Hay Fever <i>YYYY/MM/DD</i>	Tetanus <i>YYYY/MM/DD</i>	Scarlet Fever <i>YYYY/MM/DD</i>
Poliomyelitis <i>YYYY/MM/DD</i>	Mumps <i>YYYY/MM/DD</i>	Bronchitis <i>YYYY/MM/DD</i>
Concussion <i>YYYY/MM/DD</i>	Diabetes <i>YYYY/MM/DD</i>	Pneumonia <i>YYYY/MM/DD</i>
Whooping Cough <i>YYYY/MM/DD</i>		Epilepsy <i>YYYY/MM/DD</i>
10-Day Measles (Rubeola) <i>YYYY/MM/DD</i>		Hepatitis B <i>YYYY/MM/DD</i>
3-Day German Measles (Rubella) <i>YYYY/MM/DD</i>		

**Please note that upon confirmation of enrolment, you must provide the most recent copy of your child’s immunization record. If your child has not received vaccination due to a religious or conscience choice or for medical reasons, a notarized (Affidavit) Statement of Conscience of Religious Belief for Child OR Statement of Medical Exemption must be provided instead.**

Please list any other serious illnesses, injuries or operations, with approx. dates (Mandatory):

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▪ Has your child had ear infections?  Yes  No At what age/s? \_\_\_\_\_

▪ Has your child had a hearing test?  Yes  No Please describe any hearing difficulties:

\_\_\_\_\_

▪ Parents' evaluation of child's health:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**INDIVIDUALIZED PLAN FOR MEDICAL NEEDS:**

▪ Does your child have any **conditions requiring medical attention** (i.e Asthma, Febrile Seizure, Epilepsy, Physical disabilities, Severe Weakness, Etc.)? If so, please describe- including any medication or medical devices that is to be administered/ used at child care: *(please note if a child will require medication to be administered during the day you will need to fill out an authorization form, which can be requested in the Supervisor's Office*

\_\_\_\_\_

\_\_\_\_\_

▪ Does your child have any physical disabilities, severe weakness?  Yes  No

▪ Please Describe the condition and accommodation needed:

\_\_\_\_\_

\_\_\_\_\_

***If answered yes to above, parent/caregiver will be asked to devise Individualized Plan for a Child with Medical Needs (IMP) upon enrolment. If Emergency Medication is needed, parent/caregiver must fill out and Submit Administration of Medication – For Emergency or Special Circumstance Form.***

**ALLERGIES/FOOD SENSITIVITIES/ ANAPHYLAXIS:**

▪ Does your child have severe/life threatening allergies requiring Epi-Pen?  Yes  No

If so, please list allergens/ causative agents: \_\_\_\_\_

\_\_\_\_\_

Please describe signs and symptoms when in contact or upon consumption of the allergen:

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▪ Does your child have food sensitivity or restriction?  Yes  No

If so, please list all food items to be avoided:

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***In case of anaphylaxis, an 'Individualized Plan and Emergency procedures for a child with an anaphylactic allergy' will be devised with parents and/or medical officer's input upon enrolment. Parents must provide 2 epi-pens for childcare use.***

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### **INDIVIDUAL SUPPORT PLANS:**

Has your child suffered any head injuries? Please explain:

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Has your child had an eye exam?  Yes  No If so, when? \_\_\_\_/\_\_\_\_/\_\_\_\_  
YYYY / MM / DD

Does your child require corrective lenses?  Yes  No

How long has s/he been wearing them? \_\_\_\_\_

▪ Please describe any speech difficulties: \_\_\_\_\_

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▪ Has your child received a formal diagnosis indicating learning disabilities or behavioural challenges (e.g. speech delay, autism spectrum disorder, etc.)?  Yes  No

▪ **If yes, please describe and provide a full copy of the diagnostic report:**  See Attached

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***If answered Yes to above, Individual Support Plan must be devised with the input of the parent as well as the child care lead caregiver.***

5. FAMILY LIFE- GETTING TO KNOW YOUR CHILD

Does your child live with both parents?  Yes  No

Which other adults live in the household(s)? \_\_\_\_\_

\_\_\_\_\_

What is your child's bed time? *Weekdays:* \_\_\_\_\_ *Weekends:* \_\_\_\_\_

What time does your child wake-up? *Weekdays:* \_\_\_\_\_ *Weekends:* \_\_\_\_\_

Describe your child's quality of sleep: \_\_\_\_\_

How does your child awaken usually (dreamy, grumpy, etc.)? \_\_\_\_\_

Please briefly describe your child's bedtime routine? Any difficulties? \_\_\_\_\_

\_\_\_\_\_

If you read or tell stories to your child, what are some favourite titles/topics? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child nap?  Yes  No If so, for how long? \_\_\_\_\_

What does your child usually eat for breakfast? \_\_\_\_\_

\_\_\_\_\_

In your opinion, does your child have a good appetite? \_\_\_\_\_

\_\_\_\_\_

Does your child have any dietary restrictions? \_\_\_\_\_

What meals does your child have with the whole family? \_\_\_\_\_

\_\_\_\_\_



Should we be aware of any spiritual/religious festivals and holidays that are of importance to your family?  Yes  No

If so, please describe: \_\_\_\_\_

\_\_\_\_\_

How does your child/family spend the weekends/vacations? \_\_\_\_\_

\_\_\_\_\_

What responsibilities, if any, does your child have at home (e.g. helping set the table, watering a plant, putting clothes away, feeding a pet, etc.)?

\_\_\_\_\_

What activities does your child enjoy on his/her own? \_\_\_\_\_

\_\_\_\_\_

What does your child like to play with other children? \_\_\_\_\_

\_\_\_\_\_

Does your child prefer indoor or outdoor play? \_\_\_\_\_

\_\_\_\_\_

Does your child have a favourite dress-up costume? \_\_\_\_\_

\_\_\_\_\_

What activities does your child enjoy with an adult? \_\_\_\_\_

\_\_\_\_\_

What are some of the strategies or methods you use to discipline your child?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list below any early learning programs, organized sports, extra-curricular activities or groups your child has been involved with:

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Do you have any pets in your home(s)? \_\_\_\_\_

List any other places where your child has lived: \_\_\_\_\_

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Extended family:      Nearby? \_\_\_\_\_

   Distant? \_\_\_\_\_

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Please list names and ages of any other children in the household:

Names

Birthdates

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\_\_\_\_/\_\_\_\_/\_\_\_\_  
YYYY / MM / DD

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\_\_\_\_/\_\_\_\_/\_\_\_\_  
YYYY / MM / DD

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\_\_\_\_/\_\_\_\_/\_\_\_\_  
YYYY / MM / DD

Media Use:

a. Does your child watch TV or DVDs?     Yes  No    When? \_\_\_\_\_

   How often? \_\_\_\_\_

   For how long? \_\_\_\_\_

b. Does your child use the Internet, iPad, play computer games ?     Yes  No

   How often? \_\_\_\_\_

   For how long? \_\_\_\_\_

Are you willing to limit your child's media viewing and listening time? \_\_\_\_\_

6. **PERSONS AUTHORIZED TO PICK UP YOUR CHILD**

Please provide below the full names and contact information for all individuals who are authorized to pick up your child from childcare. All pick up persons must provide photo ID with their full name:

Full Name (Legal Name)	Contact Number	Relationship to child
1.		
2.		
3.		
4.		
5.		

How will your child get to and from childcare? \_\_\_\_\_

\_\_\_\_\_

7. **ANY ADDITIONAL INFORMATION**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**8. PARENT/GUARDIAN SIGNATURE**

Date of Application: (YYYY / MM / DD) \_\_\_\_\_/\_\_\_\_/\_\_\_\_

**Printed Name of Parent/Guardian completing this form:**

\_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_

*Please return the completed form to:* Karen Weyler – Childcare Supervisor  
Tel: 519- 265-8527                      Email: [kweyler@starseedlings.ca](mailto:kweyler@starseedlings.ca)

**For Office Use Only:**

Application Received Date:

Received Time:

Waitlisted:

Registration Fee Paid:

CCD Signature: