Elite Montessori Academy

elitemontessori.ca/604-221-0242

Registration Form (Page 1)

APPLICATION DATE: Day / Month / Year	CHILD START DATE: Day / Month / Year

CHILD INFORMATION

First Name	Last Name	Also known as	Date of Birth: mm/dd/yyyy

Full Address: Street No.	City	Postal code

Res. Phone	Cell Phone

PARENTS / GUARDIAN INFORMATION

Father's Name	E-Mail
Cell Phone	Work Phone
Mother's Name	E-Mail
Cell Phone	Work Phone

EMERGENCY CONTACT PERSON

Name	Relationship
Res. Phone	work/Cell Phone

Authorized Pick up Person (s): These people should be available during the hours of care

Name	Contact No.	Relationship
Name	Contact No.	Relationship

This health information may be made available to the staff of Vancouver Coastal Health.

Custody Agreement: YES N/A Provided to Facility: YES NO Immunization Document Received: Y N

Information provided by: MM DD YYYY

Please Print ____________________________ **Please Sign** _________________________ **Date** _______/_______/_______

Information received by: MM DD YYYY

Please Print ____________________________ **Please Sign** _________________________ **Date** ______/_______/_______

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CHILD INFORMATION **Registration Form (Page 2)**

Name child responds to	Person(s) with whom the child lives (adults and children)

Child's first language	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):
Fears:

Anything else you think will help us provide an enriching experience for your child.

Health INFORMATION

Health professionals involved with your child (other than doctor and dentist)

Name	*Profession/Agency*	*Phone No.*
	Family Doctor	
	Dentist	

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 info

Food sensitivities? YES NO If yes, please provide further information: