PARRY SOUND MONTESSORI

Application for Student Enrolment (CCEYA O. Reg. 137/15)

Licensed Child Care Centre
Date of Admission: ____/____/_____
Date of Discharge: ____/____/_____
CWELCC $22/day Participating

TYPE OF CARE REQUIRED:

☐ Full-Time ☐ Part-Time ☐ Academic Year (Sept–June) ☐ Summer Camp ($22/day CWELCC) ☐ Before/After School

MON	TUES	WED	THURS	FRI	SAT	SUN

1. CHILD INFORMATION

FULL LEGAL NAME | PREFERRED NAME | DATE OF BIRTH (DD/MM/YYYY)

HOME ADDRESS(ES) | LANGUAGE(S) SPOKEN AT HOME

OTHER SIBLINGS ENROLLED WITH THE CENTRE (LIST FULL NAMES):

2. PARENT & GUARDIAN INFORMATION

Parent / Guardian 1

FULL LEGAL NAME | PREFERRED NAME | RELATIONSHIP TO CHILD | PRIMARY PHONE

ALTERNATE PHONE NUMBER | EMAIL ADDRESS | ADDRESS SAME AS CHILD? ☐ Yes ☐ No

PLACE OF WORK / EMPLOYER | WORK ADDRESS & OCCUPATION | WORK PHONE & EXT.

Parent / Guardian 2

FULL LEGAL NAME | PREFERRED NAME | RELATIONSHIP TO CHILD | PRIMARY PHONE

ALTERNATE PHONE NUMBER | EMAIL ADDRESS | ADDRESS SAME AS CHILD? ☐ Yes ☐ No

PLACE OF WORK / EMPLOYER | WORK ADDRESS & OCCUPATION | WORK PHONE & EXT.

3. CUSTODY & AUTHORIZED PICK-UP CONTACTS

ARE THERE LEGAL CUSTODY ARRANGEMENTS PERTAINING TO RIGHT OF ACCESS?

☐ NO ☐ YES (Attach court order documentation)

CUSTODIAL PARENTS PERMITTED ACCESS: | PROHIBITED INDIVIDUALS (COURT ORDER REQUIRED):

Authorized Pick-Up / Emergency Contacts (Photo ID Required Upon Release)

Full Legal Name	Relationship to Child	Primary Phone	Alt Phone
1.			
2.			
3.			

4. HEALTH, DOCTOR & MEDICAL INFORMATION

DOCTOR / PHYSICIAN NAME

PHYSICIAN PHONE

CLINIC ADDRESS

SPECIAL EMERGENCY MEDICAL INFORMATION (KNOWN CONDITIONS, VISION/HEARING, SKIN CONDITIONS):

HISTORY OF COMMUNICABLE DISEASES (E.G., CHICKEN POX, MEASLES):

DOES YOUR CHILD HAVE A MEDICAL NEED REQUIRING ADDITIONAL SUPPORT (E.G. DIABETES)?

☐ NO ☐ YES (Individualized Plan required prior to start date)

Allergy & Anaphylaxis Declaration

DOES YOUR CHILD HAVE A LIFE-THREATENING / ANAPHYLACTIC ALLERGY (E.G., PEANUTS, BEE STINGS)?

☐ NO ☐ YES (Anaphylaxis Emergency Plan required prior to start date)

NON LIFE-THREATENING ALLERGIES (FOOD, LATEX, ENVIRONMENTAL):

☐ NO ☐ YES (Details below)

ALLERGY DETAILS, SYMPTOMS, AND TREATMENT INSTRUCTIONS:

5. IMMUNIZATION RECORD (PUBLIC HEALTH / MINISTRY COMPLIANCE)

Attach copy of yellow immunization card OR complete the table below. If unimmunized, an official *Statement of Medical Exemption* or *Statement of Conscious/Religious Belief* form must be provided.

Vaccine (Age Usually Given)	Dose 1 Date	Dose 2 Date	Dose 3 Date	Dose 4 Date
DTaP-IPV-Hib (2, 4, 6, 18 mos)				
Pneu-C-13 (2, 4 mos)				
Rot-1 (2, 4 mos)				
Men-C-C (12 mos) / **MMR** (12 mos)				
Varicella (15 mos) / **MMRV** (4-6 yrs)				
Tdap-IPV (4-6 yrs) / **Influenza** (Annual)				

6. DIETARY, SLEEP & PHYSICAL REQUIREMENTS

SPECIAL FEEDING / DIETARY RESTRICTIONS:

SPECIAL SLEEP / NAP COMFORT ITEMS:

TOILETING STATUS:

☐ Diapers ☐ Independent Washroom ☐ Requires Support

ADDITIONAL PHYSICAL OR BEHAVIORAL SUPPORT NEEDED:

APPENDIX A: SUPPLEMENTARY INFO FOR CHILDREN UNDER 12 MONTHS

FEEDING:

☐ Breastmilk ☐ Formula ☐ Solids Started (Pureed/Mashed/Steamed)

SLEEP ARRANGEMENTS (SAFE SLEEP POLICY):

> In accordance with Health Canada SIDS guidelines, infants under 12 months are placed on their back for sleep unless a physician orders otherwise in writing.

NAPS PER DAY	TYPICAL NAP TIMES	NAP DURATION

APPENDIX B: NON-PRESCRIPTION OVER-THE-COUNTER PRODUCTS CONSENT

> I authorize staff to apply the following non-prescription items to my child provided in the original container clearly labeled with child's name:

Product Category	Provided By Centre	Provided By Parent	Brand / Specific Instructions
Sunscreen	☐	☐	
Diaper Cream	☐	☐	
Insect Repellent	☐	☐	
Lip Balm / Moisturizer	☐	☐	
Hand Sanitizer	☐	☐	

7. POLICY ACKNOWLEDGMENT & FORMAL SIGNATURES

- **Academic & Summer Policy:** I acknowledge that the academic year runs Sept–June, after which classrooms transition to Summer Day Camp ($22/day CWELCC). Opting out of summer camp guarantees my child's academic spot for the following September.
- **Emergency Medical Consent:** In a medical emergency, staff are authorized to administer first aid/CPR and arrange transportation via ambulance to the nearest hospital.
- **Information Accuracy:** I declare that all information provided in this enrolment application is complete and accurate.

PARENT / LEGAL GUARDIAN NAME	SIGNATURE	DATE (DD/MM/YYYY)
PROVIDER NAME	**SIGNATURE**	**DATE (DD/MM/YYYY)**
AGENCY REPRESENTATIVE NAME	**SIGNATURE**	**DATE (DD/MM/YYYY)**