SMILES HEADSTART
Registration Form

☐ 3 years ☐ 4 years ☐ 5 years

☐ **Morning** **(8:30am to 12)** ☐ **Afternoon** **(1pm-3pm)** ☐ **All Day (8:30-4:30)**

Date of enrolment:__________________ Date of Withdrawal:__________________

Child's Legal Name:_________________________________ Sex: ☐ Female ☐ Male

Provincial Health Care Number:_______________________________

☐ Status ☐ Non-Status Status Number(of applicable):__________________

Clan:________________ Wilp:________________ Nation:________________

Date of Birth:__________________________ Phone Number:__________________

Address:____

Mother's Name:_____________________________ Phone Number:__________________

Address:__________________________________ Work Number:__________________

Father's Name:_____________________________ Phone Number:__________________

Address:__________________________________ Work Number:__________________

PERSONS AUTHORIZED TO PICK UP MY CHILD(REN), Include parents/guardians

Name	Relationship	Phone Number

_____________________________ _______________________ ____________________
Name Relationship Phone Number

_____________________________ _______________________ ____________________
Name Relationship Phone Number

_____________________________ _______________________ ____________________
Name Relationship Phone Number

If Applicable

☐ Separated ☐ Divorced ☐ Legal Custody ☐ Restraining Order

If there is a custody or restraining order, please give details and a copy must be attached to the child(ren)'s file.____

____

____

____

Sibling Information

Name	Gender	Birth Date
Name	Gender	Birth Date
Name	Gender	Birth Date
Name	Gender	Birth Date

HEALTH QUESTIONNAIRE
(In Case of Emergency)

1. **ADULT TO CONTACT IF YOU CANNOT BE REACHED**

Name	Relationship	Phone Number
Name	Relationship	Phone Number

2. **PHYSICIAN and/or CLINIC**

Emergency Contact Information

Name	Phone Number

3. **DENTIST and/or CLINIC**

Emergency Contact Information

Name	Phone Number

Background Information

Language(s) Spoken at Home:____

If your child has been cared for by family members or others (eg. A neighbour), Please describe the Child's experience____
____
____
____

If your child has had group play experience, please describe how often your child attended, how long and your child's experience____
____
____
____

HEALTH & DEVELOPMENTAL HISTORY

Record of Immunizations as submitted by Parent/Guardian:

PROTECTION FOR	DATES
Diptheria and Pertussis (Whooping Cough) and Tetanus	
Poliomyelitis (Polio)	
Smallpox	
Rubella	
Measles	
Mumps	
Meningitis (Influenza Type B)	

Describe any difficulties or serious illnesses at birth, if any (Premature, etc)
____
____

Describe your child's general health (eg. Recurrent colds, ear infections, stomachaches, etc)
____
____
____

If your child is taking any medication, what is the medication for:_____________________
____
____

Has your child ever been to a Dentist ☐ YES ☐ NO

Does your child have any dental problems:______________________________________
____

Describe how your child communicates:____
____
____

How would you describe your child's emotional, physical, social growth/development to this point:____
____
____
____

DIET INFORMATION

Describe your child's diet (include types of food and fluids he or she is now taking)

Fluids/Beverages:____

Solids:____

Food Allergies:____

Has your child eaten Peanut Butter at Home ☐ YES ☐ NO

Describe any particular concerns you have about your child's diet and/or eating habits:
____
____
____

Diet Restrictions (Cultural/Religious):____

How frequently does your child have a bowel movement:_________________________________

How far has your child progressed in toilet learning (if applicable)______________________
____

BEHAVIOUR PATTERNS AND HABITS

Describe how your child's behaviour and habits (eg. Temperament, energy level, etc)
____
____

Describe an ordinary day in your child's life (routine) from getting up in the morning to going to bed. Include the times for naps, meals, play and interest (Activities)
MORNINGS____
____
____

AFTERNOONS____
____
____

EVENINGS____
____
____

Describe how your child goes down for a nap (with or without a bottle, needs to be rocked, etc)____
____
____

Describe your child's particular attachments (eg. Toy, blanket, pet, person, etc.) and any particular habits (eg. Thumb-sucking, rocking,etc)_______________________________
____
____

Describe any particular fears your child has shown (eg. To animals, loud noises, strangers, etc))____
____
____

Describe how your child reacts to stressful situations (eg. Cries, withdraws, has tantrums, nightmares))____
____
____

How does your child usually react to new situations:_____________________________
____
____

We would appreciate your views on guiding your child's behaviours and setting limits:
____
____
____

Is there anything else that you would like to tell us about your child to help us provide good care:)____
____
____

_____________________________ ________________________
Parent/Guardian Signature Date Signed