SKLC APPLICATION FORM

CHILD'S INFORMATION:

CHILD'S STARTING DATE: _____/_____/_____ YY MM DD

SEX: M__ F__

DATE OF BIRTH: _____/_____/_____ YY MM DD

NAME OF CHILD:_____
Last Name First Name Nick Name Middle Initials

Name(s) the Child response to:_____

Address:_____

Postal Code:_____ Phone:_____

Person(s) with whom the Child Lives (Adults & Children):_____

Child's Primary Language:_____ Other Languages:_____

PARENT(S)/GUARDIAN(S):

Name:_____ Home Phone:_____ Cell Phone:_____

Work Phone:_____ Days/Hours of Work:_____ Email:_____

Address (if different from child):_____

_____

Name :_____ Home Phone:_____ Cell Phone:_____

Work Phone:_____ Days/Hours of Work:_____ Email:_____

Address (if different from child):_____

_____

AUTHORIZED CONTACT(S):

Person(s) authorized to pick up the child and be contacted in case of emergency. These people should be available during the hours of care. (Including Mother/Father/Guardian)

Name:_____ Relationship to Child:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Address:_____

Name:_____ Relationship to Child:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Address:_____

Name:_____ Relationship to Child:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Address:_____

Smart Kids Learning & Child Care Inc.
Unit 30, 5315 17 Ave SE – Calgary, AB – T2A 0W2
Tel: 403 454 3660 Fax: 403 454 9075
www.smartkidschildcare.ca
info@smartkidschildcare.ca

If appropriate, list an English Speaking contact:

Name:_____ Home Phone:_____ Cell Phone:_____

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 – Toys / Blankets):_____

Eating / Mealtime (Include food likes / dislikes):_____

Fears:_____

Please tell us anything else you think will help us provide an enriching experience for your child: _____

_____

HEALTH INFORMATION **Alberta Health Card # _____**

Health Professionals involved with your child (Other than Doctor and Dentist):

NAME	PROFESSION / AGENCY	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____

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:_____

Special diet related to medical condition: ☐Yes ☐No

If Yes, please provide further information:_____

Food sensitive: ☐Yes ☐No

If Yes, please provide further information:_____

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HEALTH INFORMATION

List all prescription and "Over the Counter" medication your child receives:

Medication	Times Given	Reasons for Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any other relevant health information:_____

For Part Time: Please check below the required days of care for your child per week:

☐ 4 Days ☐ 3 Days ☐ 2 Days

Note: We also accept Drop-Ins for Professional Days and other Non-Instructional Days & Holidays
Drop-In Fee: $60.00 / Day

Custody Agreement ☐Yes ☐N/A **Provided to Facility** ☐Yes ☐No ☐N/A

Immunization up to date?: ☐Yes ☐No

Information Provided By:

_____/_____/_____ _____ _____
YY MM DD Print Name Signature

Information Received By:

_____/_____/_____ _____ _____
YY MM DD Print Name Signature

OFFICE USE ONLY

Date Child Leaves the Facility: Date_____/_____/_____
YY MM DD

Consent to call for emergency medical: ☐Yes ☐No

I _____ give my consent to _____ call medical emergency if and when needed.

_____ _____
Parent Signature Date

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