

# Child's Play Group

## Vacation Care Enrolment Form

Please complete and return a form for each child.

### CHILD INFORMATION *(Please give names and details EXACTLY as on birth certificate)*

Family Name: \_\_\_\_\_ First name(s): \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M / F \_\_\_\_\_  
Grade: \_\_\_\_\_  
Residential Address: \_\_\_\_\_  
City: \_\_\_\_\_ Post Code: \_\_\_\_\_  
Cultural Background: \_\_\_\_\_ First Nations: Y / N \_\_\_\_\_  
Country of Birth: \_\_\_\_\_ Language(s) spoken at home: \_\_\_\_\_

### PARENT/GUARDIAN INFORMATION – ACCOUNT HOLDER

*(Please give full name and details EXACTLY)*

Title: \_\_\_\_\_ Family Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Relationship to Child: \_\_\_\_\_  
Residential Address: \_\_\_\_\_  
City: \_\_\_\_\_ Post Code: \_\_\_\_\_  
Daytime Address: \_\_\_\_\_  
City: \_\_\_\_\_ Post Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

### PARENT/GUARDIAN INFORMATION *(Please give full name)*

Title: \_\_\_\_\_ Family Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Relationship to Child: \_\_\_\_\_  
Residential Address: \_\_\_\_\_  
City: \_\_\_\_\_ Post Code: \_\_\_\_\_  
Daytime Address: \_\_\_\_\_  
City: \_\_\_\_\_ Post Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

**EMERGENCY CONTACTS** I consent for the following contacts, to collect my child from service including in the event of any incident, injury, trauma & illness and to act as an Authorized Nominee consent to medical treatment of the child or to authorize the administration of medication to the child. *(You must nominate at least one person **other than parent/guardian** aged over 18 years of age)*

**Contact 1** Title: \_\_\_\_\_ Family Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Relationship to Child: \_\_\_\_\_ Tel: \_\_\_\_\_ Cell: \_\_\_\_\_  
Address: \_\_\_\_\_  
**Contact 2** Title: \_\_\_\_\_ Family Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Relationship to Child: \_\_\_\_\_ Tel: \_\_\_\_\_ Cell: \_\_\_\_\_  
Address: \_\_\_\_\_

# Child's Play Group

## Vacation Care Enrolment Form

Please complete and return a form for each child.

**Details of Approved Pick up persons** I consent to for the following contacts to collect my child from service including in the event of any incident, injury, trauma & illness (other than parent/guardian, must be aged over 18 years of age)

**Contact 1** Title: \_\_\_\_\_ Family Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Tel: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_

**Contact 2** Title: \_\_\_\_\_ Family Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Tel: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_

**Note\*** We may not release your child to an unlisted person without prior written notification. If any person not listed and not known to the Sherpa Kids staff, should attempt to collect your child from the service, permission will be refused.

**With whom does the child mostly reside?** \_\_\_\_\_

**Is this child involved in court orders, parenting plans or orders?**  Yes  No

If yes, please provide current and any changes to court documents at all times to enable enforcement. Please list below any other specific instructions or information you can provide that would be helpful and assist us in the care of your child.

### MEDICAL DETAILS & OTHER INFORMATION

**Alberta Health Care Number:** \_\_\_\_\_

**Does your child have any of the following:**

- |  |  |
|--|--|
| <input type="checkbox"/> A.D.D. / A.D.H.D          | <input type="checkbox"/> Epilepsy                      |
| <input type="checkbox"/> Allergies (see box below) | <input type="checkbox"/> Haemophilia                   |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Heart problems                |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Anaphylaxis                   |
| <input type="checkbox"/> Physical needs            | <input type="checkbox"/> Behavioural needs             |
| <input type="checkbox"/> Educational needs         | <input type="checkbox"/> any other special needs _____ |

**Is your child on any medication?** (Please complete a Medical Information & Authorisation Form)  Yes  No

**Has your child been immunised?**  Yes  No

**Does your child wear?**  Prescriptions Glasses  Hearing Aid

**Does your child have any of the following allergies?** Please indicate severity e.g. High, Moderate, Low or Not Applicable

<b>1. Bee Sting</b>	<input type="checkbox"/> High	<input type="checkbox"/> Moderate	<input type="checkbox"/> Low	<input type="checkbox"/> N/A
<i>Medication or Action to be taken:</i>				<input type="checkbox"/> N/A
<b>2. Food Allergy</b>	<input type="checkbox"/> High	<input type="checkbox"/> Moderate	<input type="checkbox"/> Low	<input type="checkbox"/> N/A
<i>Names of food/s &amp; action to be taken</i>				<input type="checkbox"/> N/A
<b>3. Allergy to Medication</b> Please name medication & action to be taken:				<input type="checkbox"/> N/A
<b>4. Other Allergies</b> Please describe & action to be taken (inc bandaids, latex etc)				<input type="checkbox"/> N/A
<b>Please provide information on any other dietary, cultural or religious considerations or special instructions regarding the health and well-being of your child</b> (e.g. excessive fears)				<input type="checkbox"/> N/A

# Child's Play Group Vacation Care Enrolment Form

Please complete and return a form for each child.

## Please read and sign the following statements:

I hereby give permission to the staff of the above Child's Play Group program to administer medically prescribed medication to my child and I will sign a Medical information & Authorization form. I understand that the staff will record each administration of medication. I acknowledge that all care will be taken and will not hold Child's Play Group responsible. I also understand my child cannot attend Child's Play Group if suffering from an infectious or communicable disease that has been identified by the Department of Health

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby notify Child's Play Group that my child carries medication with them and will self-medicate. I understand I will provide a letter/plan from a doctor to support this and I will sign a Medical information & Authorization form.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby give my permission for the Child's Play Group staff to treat my child if a minor accident occurs. In the case of a more urgent matter I understand an ambulance will be called first then I will be notified and agree to meet any expenses incurred.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I understand the provider of the Child's Play Group service is not liable for any personal injury, loss or damage to personal property due to any cause whatsoever unless there is proven negligence by the provider or employee.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I understand Child's Play Group staff have no responsibility to my child until I or an authorized person has signed my child in/out for each session of care.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby give Child's Play Group permission to transport my child off a Child's Play Group designated site of operation if and when required and risk assessment plans will be undertaken for each occasion (e.g. evacuation, group trip).

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I acknowledge that photographs/video of my child or items of my child's work completed at the Child's Play Group program may be used at a later date for local marketing and promotional purposes  Yes  No national marketing and promotional purposes  Yes  No  I hereby give my consent and no further permission will be required.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I acknowledge that the information contained herein is confidential and pursuant to the Privacy Act, will only be strictly used by the Child's Play Group team to effectively care for my child and not used or distributed for any other purposes. Representatives from appropriate Government Departments may view this information as part of the program assessment process.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby give permission for my child to watch G & PG rated movies and games.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Return forms to your child's centre or email to  
[info@calgarychildsplay.com](mailto:info@calgarychildsplay.com)

Office Use Only: Date Processed: \_\_\_\_\_

Staff Initial: \_\_\_\_\_

