Town Of Drayton Valley Early Childhood Development Centre
5024- 48th Street
Drayton Valley, AB
514-2200 (phone) 542-5753 (Fax)
www.town.draytonvalley.ab.ca

Early Childhood Centre Registration Form

Child's Starting Date: _____/_____/_____ Year Month Day

Date of Birth: ___/____/___ Yr. Mos. Day

Sex: M___F___

Name child responds to: _____ (Surname) (Given name) (Also known as)

Address: _____

Postal Code: _____ Phone: _____ Cell: _____

Person(s) with whom child lives (adults & siblings):_____

_____

Child's First Language: _____ Second Language: _____

Parent (s) / Guardian (s):

Name:_____ Home Phone: _____

Work Phone: _____ Cell: _____ Day/Hours of work _____

Name:_____ Home Phone: _____

Work Phone: _____ Cell: _____ Day/Hours of work _____

Emergency Contacts: (persons authorized to pick up child and/or be contacted in case of emergency include (siblings/ extended family members/ friends of family)

Name: _____ Relationship to Child:_____

Home Phone: _____ Work ph. _____ Cell ph. _____

Name: _____ Relationship to Child: _____

Home Phone: _____ Work ph. _____ Cell ph. _____

Name: _____ Relationship to Child: _____

Home Phone: _____ Work ph. _____ Cell ph. _____

Name: _____ Relationship to Child:_____

Home Phone: _____ Work ph. _____ Cell ph. _____

If appropriate English speaking contact:

Name_____ Phone_____

****If there is a custody agreement, please give details and attach copy:**

_____

_____

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Has child previously attended daycare / preschool?

Yes _____ No _____ If yes where? _____

Health Information

Family Doctor: _____ Phone: _____

Family Dentist: _____ Phone: _____

Other health professionals involved with your child:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Alberta Health Care # (or out of province number)

_____

If appropriate please comment here on any other health issues:

Special Medications: _____ Vision or Hearing: _____

Allergies: _____ Speech/ Language: _____ Other:_____

_____

_____

Written Consent is given for: (please check all items for which you give your consent)

☐ immediate first aid if needed from certified staff

☐ transportation to the hospital should medical attention be needed.

☐ daily transportation by the facility (facility has the option to offer)

If your child is transported by the facility are there any instructions for special care for the child (eg. Motion sickness, seizures etc) during transportation.

☐ Yes If yes, specify: _____

☐ No _____

Parents' comments if any:

_____

_____

_____

_____ Date: _____

Signature of person filling out application Year / Month / Day