



**DAYCARE APPLICATION
FOR CHILDREN 0-5 YEARS
2018-2019**

Child's Full Name:

Kids Klub Start Date:

Age:

Birth date:

Check the type of care you require:

Little Beavers Full Year Program Monday-Friday 7:30am-5:30pm (Closed December 24th – Dec 28th, 2018)	Full Time Care (Under 3yrs): \$1,050.00 per month Full Time Care (Over 3yrs): \$875.00 per month
Drop In Care (Based upon availability)	Little Beavers \$55.00 per day

I understand that by enrolling my child for the above program, I am responsible for the total cost of care.
I understand that if I wish to withdraw my child I am required to give Kids Klub **Four Weeks** written notice.

Parent Signature

Name (Please Print)

Date

**PLEASE RETURN TO KIDS KLUB HEAD OFFICE AT:
4828 WEST SAANICH RD. VICTORIA, BC V8Z 3H5
PHONE: (250) 881-1223 FAX: (250) 881-1146
EMAIL: registration@kidsklub.ca
WWW.KIDSKLUB.CA**



Application for Registration

A Non-Profit Christian-Based Organization Committed to Providing Quality Child Care

Family Information	<p>Child's Name: _____ Age: ___ Birth date: _____ Gender: M ___ F ___</p> <p>Name of Enrolling Parent: _____ Cell Phone: _____</p> <p>Street Address: _____ Home Phone: _____</p> <p>City: _____ Postal/Zip: _____ E-mail: _____</p> <p>Employer: _____ Work Phone: _____</p> <p>Name of Second Parent: _____ Cell Phone: _____</p> <p>Street Address: _____ Home Phone: _____</p> <p>City: _____ Postal/Zip: _____ E-mail: _____</p> <p>Employer: _____ Work Phone: _____</p> <p>Siblings Names & Ages: _____</p> <p>(only if in Kids Klub) _____</p>
Custody Restrictions	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If so please attach court order and state general conditions here: _____</p> <p>Names of people <i>not authorized</i> to have access to your child: _____</p>
Emergency Contacts And Persons Authorized To Pick Up Child	<p>Name: _____ Relationship: _____</p> <p>Home Phone: _____ Work Phone: _____ Cell Phone: _____</p> <p>Name: _____ Relationship: _____</p> <p>Home Phone: _____ Work Phone: _____ Cell Phone: _____</p> <p>Name: _____ Relationship: _____</p> <p>Home Phone: _____ Work Phone: _____ Cell Phone: _____</p> <p>Name: _____ Relationship: _____</p> <p>Home Phone: _____ Work Phone: _____ Cell Phone: _____</p> <p>Name: _____ Relationship: _____</p> <p>Home Phone: _____ Work Phone: _____ Cell Phone: _____</p>
Arrivals & Departures	<p>CHILDREN WILL NOT BE RELEASED ON THEIR OWN. CHILDREN MUST BE SIGNED IN AND OUT OF THE PROGRAM BY A PARENT OR BY A PERSON AUTHORIZED TO PICK UP.</p>

Health

Family Doctor _____ Phone _____

BC Medical Health Number _____

Has your child had any serious health problems that we need to be aware of? Yes No

If yes, explain: _____

Does your child have any Support Needs? Yes No

If yes, explain: _____

Does your child take any regular medications: Yes No

If yes, explain: _____

IF YES YOU MUST COMPLETE AN 'AUTHORIZATION TO ADMINISTER MEDICATION FORM' AVAILABLE AT THE KIDS KLUB LOCATION YOUR CHILD IS ATTENDING.

Have you noticed an allergy to any particular food or insects? Yes No

If yes, explain: _____

Special Diet/Food Preferences: _____

Immunization

**BASIC SCHEDULE AND RECORD OF IMMUNIZATION AS SUBMITTED BY PARENT/GUARDIAN
(ATTACH IMMUNIZATION RECORD - OR RECORD THE DATES)**

First Visit – two months of age: YYYY / MM / DD	Fourth Visit – 12 months of age: YYYY / MM / DD
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Measles
<input type="checkbox"/> Pertussis	<input type="checkbox"/> Mumps
<input type="checkbox"/> Tetanus	<input type="checkbox"/> Rubella
<input type="checkbox"/> Polio	<input type="checkbox"/> Meningococcal C Conjugate
<input type="checkbox"/> Haemophilus Influenza Type b (hib)	<input type="checkbox"/> Varicella (chicken pox)
<input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> Pneumococcal Conjugate	Fifth Visit – 12 months after third visit: YYYY / MM / DD
<input type="checkbox"/> Meningococcal C Conjugate	<input type="checkbox"/> Diphtheria
	<input type="checkbox"/> Pertussis
Second Visit – two months after first visit: YYYY / MM / DD	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Polio
<input type="checkbox"/> Pertussis	<input type="checkbox"/> Haemophilus Influenza Type b (hib)
<input type="checkbox"/> Tetanus	<input type="checkbox"/> Measles, Mumps, Rubella
<input type="checkbox"/> Polio	<input type="checkbox"/> Pneumococcal Conjugate
<input type="checkbox"/> Haemophilus Influenza Type b (hib)	
<input type="checkbox"/> Hepatitis B	4 to 6 years of age: YYYY / MM / DD
<input type="checkbox"/> Pneumococcal Conjugate	<input type="checkbox"/> Diphtheria
	<input type="checkbox"/> Pertussis
Third Visit – two months after second visit: YYYY / MM / DD	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Polio
<input type="checkbox"/> Pertussis	<input type="checkbox"/> Varicella (chicken pox)
<input type="checkbox"/> Tetanus	
<input type="checkbox"/> Polio	Other Immunizations:
<input type="checkbox"/> Haemophilus Influenza Type b (hib)	YYYY / MM / DD
<input type="checkbox"/> Hepatitis B	YYYY / MM / DD
<input type="checkbox"/> Pneumococcal Conjugate	YYYY / MM / DD

PLEASE NOTE: Vancouver Island Health Authority requires these dates to be on file.

Kids Klub does not keep these dates on record from year to year.

Please check box if you have chosen not to immunize your child Parent's initial _____

General	<p>Has your child previously attended a daycare? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Is there any other information about your child that would be helpful for the staff in order to best care for your child? (Needs, concerns, interests, hobbies, etc.)_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
Policies & Procedures	<p align="center">Please refer to the attached PROGRAM CONDITIONS and GUIDANCE AND DISCIPLINE POLICIES.</p> <p>I have read and accept the Program Conditions and Guidance and discipline policies.</p> <p align="center">_____</p> <p align="center">Signature Date</p>
Permissions	<ol style="list-style-type: none"> 1. I hereby give permission for my child _____ to go on walking trips arranged by Kids Klub Program Staff: <input type="checkbox"/>Yes <input type="checkbox"/>No 2. I hereby give permission to have pictures taken of my child in the program setting for publicity purposes: <input type="checkbox"/>Yes <input type="checkbox"/>No 3. I understand that in case of accident or illness, if a parent or guardian cannot be reached, Kids Klub will phone an ambulance and a staff will accompany your child to the hospital. I give my authorization for emergency health services. 4. I accept all responsibility for payment of all accounts rendered to my family. 5. I certify that the information given in this form is complete and true in every respect, and that I am the legal Parent/Guardian of _____. <p align="center">_____</p> <p align="center">Signature Date</p>



Payment Agreement

2018/2019

Parent Name: _____

Child Name: _____

PLEASE SELECT ONE OF THE FOLLOWING PAYMENT OPTIONS:

Payment Option # 1 PRE-AUTHORIZED PAYMENT

Monthly
 1st \$ _____
 Commencing _____ 201__
Month
Year

PLEASE ATTACH A VOID CHEQUE AND SIGN BELOW
 These services are for personal

Payment Option # 2 VISA/MASTERCARD

Monthly
 1st \$ _____
 Commencing _____ 201__
Month
Year

Full name of Card Holder: _____

***** To have the *Registration fee* charged to your card, please initial here _____**

Expiration Date: /
Month
Year

MasterCard Number 5

VISA Number 4

I hereby authorize Vancouver Island Kids Klub Centre Society through Royal Bank of Canada (*Payment Option #1*) to make the above scheduled debits from my chequing account **or** Moneris Solutions (*Payment Option #2*), to make debits from my credit card on a monthly basis. This authorization is to remain in effect until cancelled in writing, or until the childcare program period ends. These withdrawals are for the purchase of personal services.

Parent Signature (Account Holder)

Date