ABORIGINAL HEADSTART & DAYCARE REGISTRATION APPLICATION

DATE OF APPLICATION: _____

1. CHILD INFORMATION

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Gender: ◯ M ◯ F Date of Birth: _____

First Nation/Band: _____

Language spoken in the home: First: _____ Second: _____

2. OTHER SERVICES

Has your child received services from any of the following:

☐ Early Childhood Intervention Program (ECIP) ☐ Speech and Language Pathologist

☐ Occupational Therapist ☐ Early Childhood Psychologist ☐ ICFS ☐ Other Services

Medical Information

Does your child have any medical conditions: ☐ Yes ☐ No If yes, please explain.

_____

_____

Other information that should be known about the child?

_____

_____

3. PARENT/GUARDIAN INFORMATION

Parent/Guardian Last Name: _____ First Name: _____

Phone: _____ Cell: _____

Parent/Guardian Last Name: _____ First Name: _____

Phone: _____ Cell: _____

PRE-SCHOOL HEALTH & SOCIAL RESUME

Child's Name: _____

Does your child have a nickname? ◯ Yes ◯ No. If yes, what is it? _____

Family:

Names of brothers and sisters, (include nicknames)	Birth dates	Does this sibling live in the same home as this child?

Names of others living in the home	Relationship to child

Does your child have any pets? ◯ Yes ◯ No. If yes, what are they? _____

Food:

Describe your child's appetite: _____

_____

What food does your child dislike: _____

What food does your child like: _____

What foods do you not permit your child to eat? _____

Does your child feed him/herself? ◯ Yes ◯ No. If help is needed, what kind of help?

_____

What time does your child usually eat:

Breakfast: _____ Lunch: _____ Snacks: _____ Supper: _____

Self Care:

Please comment about bathroom routines or training procedures:

Is your child in diapers? ◯ Yes ◯ No

Has training begun? ◯ Yes ◯ No

Is your child completely trained? ◯ Yes ◯ No

Does your child need help with bath rooming? ◯ Yes ◯ No

Does your child need any help with dressing? ◯ Yes ◯ No. If yes, what kind of help?

_____

Does your child nap? ◯ Yes ◯ No. If yes, what are his/her naptime routines?

_____

_____

Do you, or does your child, have any concerns relating to nap time? ◯ Yes ◯ No. Please describe:

_____

_____

Social/Emotional Development:

Does your child separate easily from you? ◯ Yes ◯ No.

Please comment: _____

Is your child shy? ◯ Yes ◯ No ◯ Sometimes

With whom? _____ When? _____

Is your child afraid of anything? ◯ Yes ◯ No

Please describe:

_____

How does your child show feelings of:

Affection _____

Fear _____

Anger _____

Frustration _____

Excitement _____

Does your child have a favorite toy, blanket, bottle or soother? ◯ Yes ◯ No. Please identify:

_____

Has your child experienced play with other children? ◯ Yes ◯ No. Please describe

_____

Does your child have any imaginary playmates? ◯ Yes ◯ No. If yes, please comment:

_____

What activities does your child like? _____

What activities does your child dislike? _____

How do you handle discipline in your home? _____

_____

_____

What characteristic in your child's development would you like:

Encouraged? _____

Discouraged? _____

Provide any further information relating to your child that would be helpful in understanding and caring for your child.

_____

_____

_____

_____

_____

Date: _____/_____/_____

Year/Month/Day

Parent/Guardian Signature_____

COPY TO BE PLACED IN CHILD'S FILE

_____

Food

Describe your child's appetite: _____

What foods do you not permit your child to eat? _____

What time does your child usually eat: Breakfast _____ Lunch _____ Snack _____ Supper _____

Provide any further information relating to your child with regard to food or eating?

_____

_____

_____

Self-Care Does your child need any help dressing? ◯ Yes ◯ No If Yes, identify areas of difficulty:

_____

_____

_____

Does your child need any help with toileting? ? ◯ Yes ◯ No If Yes, identify areas where assistance is required:

_____

_____

_____

Social/Emotional Development

How does your child show feeling of?

Affection _____

Worry _____

Fear _____

Anger _____

Frustration _____

Excitement _____

Is your child shy? ◯ Yes ◯ No ◯ Sometimes

With whom? _____

When? _____

Does your child enjoy:

	Often	Sometimes	Never
Playing by himself?	◯	◯	◯
Playing with younger children?	◯	◯	◯
Playing with own-age children?	◯	◯	◯
Playing with older children?	◯	◯	◯
Being with adults?	◯	◯	◯

Does your child make new friends easily? ◯ Yes ◯ No Please comment:

Does your child have any imaginary playmates? ◯ Yes ◯ No If Yes, please describe:

What activities does your child like?

What activities does your child dislike?

Is your child enrolled in any extracurricular activities? ◯ Yes ◯ No Please list

How do you handle discipline in your home?

What characteristics in your child's development would you like?

Encouraged

Discouraged

Please provide any further information relating to your child that would be helpful in understanding and caring for your child.

RELEASE OF CHILD

I hereby give my authorization for the following persons (over 14 years of age) to pick up my child/children from the Early Childhood Program.

Name of child/children: _____

1. Name: _____

   Address: _____

   Home Phone: _____

   Cell Phone: _____

2. Name: _____

   Address: _____

   Home Phone: _____

   Cell Phone: _____

3. Name: _____

   Address: _____

   Home Phone: _____

   Cell Phone: _____

4. Name: _____

   Address: _____

   Home Phone: _____

   Cell Phone: _____

Any person, whose name does not appear on this list, will only be permitted to take the child/children from the program with a phone call to the Early Childhood Program.

Staff are not permitted to take children home at the end of the workday without prior arrangements.

Parent's Signature: _____ Date_____

Director's Signature: _____ Date_____

COPY TO BE PLACED IN CHILD'S FILE

Date: _____/_____/_____

Year Month Day

_____

Parent/ Guardian signature

COPY TO BE PLACED IN CHILDS FILE

CHILD'S MEDICAL CERTIFICATE

Child's Name: _____ Date of Birth: ____/____/____

Y M D

Are the child's immunizations up to date? ◯ Yes ◯ No

Child's Medical History:

Check any of the following illness which the child has had:

☐ Asthma	☐ Earaches	☐ Mumps	☐ Whooping cough
☐ Bronchitis	☐ Eczema	☐ Pneumonia	☐ Convulsions
☐ Chicken Pox	☐ Frequent colds	☐ Polio	☐ Measles German
☐ Influenza	☐ Rheumatic fever	☐ Croup	☐ Measles Red
☐ Scarlet Fever	☐ Diphtheria	☐ Tonsillitis	
☐ Other: List: _____		☐ Injuries: List _____	

Allergies:

Does the child have any known medication allergies? ◯ Yes ◯ No. If Yes, what are they and what is the child's reaction to them?

_____

_____

Does the child have any known food allergies? ◯ Yes ◯ No. If Yes, what are they and what is the child's reaction to them?

_____

_____

Does the child have any other allergies? ◯ Yes ◯ No. If Yes, what are they and what is the child's reaction to them?

_____

_____

TRANSPORTATION RELEASE FORM (REQUIRED FORM)

Saskatchewan First Nations Early Learning and Child Care Regulations require Early Childhood programs that provide transportation to and from the facility, to have written authorization from parents/ guardians

See the attached Policy – Saskatchewan First Nations Early Childhood Regulations *(Regulation 7 – 7.5)*

Transportation Procedures:

- Children are picked up and dropped off at each child's home.
- Parents are required to bring the child to the vehicle and buckle/unbuckle the child in the seat at time of pick up/drop off.
- ~~At each stop the bus/van driver will wait 2 min for child, if there is no sign of child/parent appearing the bus/van will leave. Parents may bring child to the program.~~
- When a child is taken home they can only be left with a parent or a designated person over the age of 14 years, otherwise the child will be returned to the program facility. All attempts will be made to contact the parents or emergency contacts. If no one is found then Child and Family Services will be called.
- WINTER DRIVING: when the temperature falls to _____ degrees (with the wind chill factor), transportation to/from the program will not be provided. Parents can still bring their child to the program but must inform the program.
- Decisions around closures due to inclement weather and other situations will be communicated to you in a timely manner.
- Children must be dressed appropriately for the weather or they will not be accepted on the bus/van.

I hereby give permission to the Early Childhood Program for my child_____ *to* be transported to and from the Head Start program.

I have read, understand and agree to comply with the above procedure.

_____ *(Parent/Guardian signature)*

COPY OF THIS AGREEMENT IS GIVEN TO PARENT/GUARDIAN AND ONE IS KEPT IN THE CHILD'S FILE.

C0NSENT FOR IMMUNIZATION STATUS

I, _____ , authorize _____,
(Parent/guardian) Director/Coordinator
at _____ to request my child's immunization information
(Name of facility)
from the _____ Health Center.

Child's name: _____ Age: _____

_____ _____
(Parent's Signature) (Date)

Immunizations for _____ are up to date ◯ Yes" ◯ No

If "no" what is the planned schedule to bring the child's immunizations up to date?

Immunization Required:	Scheduled Appointment:

_____ _____
(Community Health Nurse) Date

I, _____ , have chosen not to have my child,
(Parent/guardian)
_____ immunized. I understand that if my child contracts
(Child's name)
any of the diseases that are preventable with immunizations, (see attached list) they will not be allowed to attend the _____ Early Childhood Program until cleared by a doctor or the Community Health Nurse.

_____ _____
Parent's Signature Date

COPY TO BE PLACED IN CHILD'S FILE.

COPY TO BE PROVIDED TO PARENT/GUARDIAN

Other Medical Information:

Does the child take any medication on a regular basis? ◯ Yes ◯ No. If Yes, give the name of the medication and the medical condition for which it is taken;

_____

_____

Do you have any concerns about the child's development? ◯ Yes ◯ No. If Yes comments:

_____

_____

Are there any restrictions on the kind and/or amount of physical activity in which the child may participate? ◯ Yes ◯ No. If Yes, identify: _____

Has the child ever undergone surgery? ◯ Yes ◯ No. If Yes, list: _____

_____

_____

Are there any special diets necessary for the child's health? ◯ Yes ◯ No. If Yes, describe:

_____

_____

_____

Please comment on any other medical information the Early Childhood Program (s) should be aware of:

_____

_____

_____

_____

I _____ have carried out a complete examination of the above named child and consider that the child:

◯ Is capable to participate in an Early Childhood Program.

◯ Is not capable to participate in an Early Childhood Program.

Comments:

_____

_____

_____

Physician's Signature: _____ Date: _____

COPY TO BE PLACED IN CHILD'S FILE.

CONSENT FOR USE OF PHOTOS

By signing this release form I give permission to Okhapawace Nation Tribal Council to use and display photographs of my child/children in any print publication (brochures, newsletters, annual reports, presentations and calendars), or internet publication.

Furthermore, I understand the photograph(s) will be used for educational purposes only in promoting awareness and understanding of healthy early childhood development.

_____

Signature of Parent/Guardian

_____ _____

Name of Witness (Please Print) Signature of Witness

_____

Date

PERMISSION FOR PARTICIPATION IN PROGRAM

I, _____ give my child _____ permission:

- ☐ To participate in off premises excursions not involving transportation (walking only)
- ☐ To be transported in off premises excursions on regular outings (motor vehicle)
- ☐ To take part in activities covered by media (research, photography, video-taping)
- ☐ To track my child for individual assessment , and for program evaluation purposes (Brigance, Ages and Stages (ASQ) or other screening tool)
- ☐ To participate in the Dental program.
- ☐ To participate in the Health Promotions activities provided through the Community Nurses and Dieticians.

Parents Signature _____ Date: _____

COPY TO BE PLACED IN CHILD'S FILE