Cochrane Child Care Centre Registration

REQUESTED START DATE:

CHILD'S NAME:	MALE ☐ FEMALE ☐	DATE OF BIRTH (D/M/Y)

SCHOOL ATTENDING (if applicable)

PARENT/GUARDIAN NAME:
ADDRESS:
MAILING ADDRESS (if different):
EMAIL ADDRESS:
PHONE NUMBER:
PLACE OF WORK:
WORK PHONE NUMBER:
WORK ADDRESS:

PARENT/GUARDIAN NAME:
ADDRESS:
MAILING ADDRESS (if different):
EMAIL ADDRESS:
PHONE NUMBER:
PLACE OF WORK:
WORK PHONE NUMBER:
WORK ADDRESS:

IS THERE A COURT ORDER IN EFFECT REGARDING THE CUSTODY OF THE CHILD? YES ☐ NO ☐
IF YES, WHAT ARE THE CONDITIONS?

PLEASE PROVIDE PROOF OF CUSTODY

PERSON(S) AUTHORIZED TO PICK UP CHILD:

NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

UNDER NO CIRCUMSTANCES WILL A CHILD BE RELEASED TO ANYONE WITHOUT AUTHORIZATION FROM THE PARENTS OR GUARDIAN. IDENTIFICATION MAY BE REQUESTED

ALTERNATE PERSON: **EMERGENCY CONTACT OTHER THAN PARENT/GUARDIAN**

NAME:	PHONE:
RELATIONSHIP TO CHILD:	ADDRESS:

FAMILY PHYSICIAN:
ADDRESS:
PHONE NUMBER:

FAMILY DENTIST:
ADDRESS:
PHONE NUMBER:

GENERAL HEALTH:
SUPPORT NEEDS:
ALLERGIES (food/medication/animals/bees etc.):
MEDICATIONS:
SERIOUS ILLNESS:
INJURIES:

CHILDHOOD ILLNESS – HAS YOUR CHILD HAD?

CHICKENPOX	MEASELS (RED)
MEASLES (GERMAN)	MUMPS

AMOUNT OF ADULTS IN THE HOME?
RELATIONSHIP:
NUMBER OF CHILDREN IN THE FAMILY:
NAMES/GENDER/AGES:

CHILD'S PREVIOUS EXPERIENCE IN A GROUP:

GUIDANCE AND CONTROL METHODS THAT THE CHILD RESPONDS TO:

ADDITIONL INFORMATION WHICH WILL HELP US TO KNOW YOUR CHILD (likes/dislikes/fears etc.)

WHAT DO YOU HOPE THAT YOUR CHILD WILL GAIN FROM THEIR CHILD CARE EXPERIENCE?

ANY LANGUAGES SPOKEN OTHER THAN ENGLISH:

I, the undersigned, agree to adhere to the policies of the Cochrane Child Care Centre.

SIGNED: Parent(s) or Guardian_____DATE:_____

SIGNED: Parent(s) or Guardian_____DATE:_____

EMERGENCY CARE

I hereby consent for my child to be transported to the hospital in case of emergency, and consent to emergency treatment until the time of my arrival at the hospital. I understand that every effort will be made to contact me if such an emergency takes place.

SIGNED: Parent(s) or Guardian_____DATE:_____

SIGNED: Parent(s) or Guardian_____DATE:_____

FOR OFFICE USE ONLY

DATE RECEIVED	START DATE	WITHDRAWL DATE

CORPORATION OF THE TOWN OF COCHRANE

COCHRANE CHILD CARE CENTRE/GARDE D'ENFANTS DE COCHRANE

CHILD CARE FEE PAYMENT AGREEMENT

PARENT/GUARDIAN: _____ TELEPHONE: _____

ADDRESS: _____

_____

CHILD/CHILDREN: _____

_____

_____

MY CHILD/CHILDREN WILL ATTEND COCHRANE CHILD CARE CENTRE/GARDE D'ENFANTS DE COCHRANE:

MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

BETWEEN THE HOURS OF: _____ A.M. /P.M. AND _____P.M.

☐ I AGREE TO PAY THE FEES INCURRED FOR CHILD CARE, **IN ADVANCE.**

☐ CHILD WILL ATTEND ON A CALL IN BASIS (Providing space is available.)

☐ BIWEEKLY PAYMENT ☐ MONTHLY PAYMENT

Daily fees are as follows:				
	Full Day Infant Program	$37.50		
	Full Day	$38.00	Camp Rates: 1st Child	$38.00
	Before School	$7.50	2nd Child	$29.75
	After School	$12.50	3rd Child	$24.85

CANADA WIDE EARLY LEARNING and CHILD CARE RATES APPLY FOR THOSE WHO QUALIFY

Subsidy Information (please check off)

☐ I have applied for subsidy. (A copy of the parent agreement is attached.)

☐ I have a parental contribution of _____ daily that will be paid by me. I will be responsible for the payment of the parental contribution regardless if my child is in attendance or not. Cochrane Child Care Centre's policy for absent days does not apply to parents receiving fee subsidy.

☐ I also understand that should I run out of my allotted absent days covered by DSSAB subsidy (36 days per child or pro-rated allowance) I am responsible to pay the full daily child care cost for any above this allotment. _____ (Parent/Guardian initials) Allowance applies to illness and family emergencies.

_____ _____

STAFF WITNESS SIGNATURE PARENT/GUARDIAN SIGNATURE

_____ _____

DATE DATE

I UNDERSTAND:

- **FEES** FOR CHILD CARE SERVICES ARE CALCULATED ON A MONTHLY BASIS AND ARE DUE IN FULL IN **IN ADVANCE**.
- **SHOULD** THE TIME PERIOD OF CARE EXCEED THE AFORE MENTIONED TIMES, MY RATE WILL INCREASE ACCORDINGLY.
- A LATE FEE OF $25.00 WILL BE CHARGED PER 15 MINUTE INCREMENTS.
- THE CENTRE REQUIRES **2 WEEKS WRITTEN NOTICE** IF YOUR CHILD IS BEING WITHDRAWN, IF NO NOTICE IS GIVEN, YOU WILL BE BILLED THE ADDITIONAL TWO WEEKS AT YOUR REGULAR DAILY RATE. **YOU ARE RESPONSIBLE FOR PAYMENT ON YOUR CHILD'S LAST DAY.**
- REFUNDS ARE NOT APPLICABLE FOR ABSENT DAYS OR FOR CIRCUMSTANCES OUT OF THE CONTROL OF THE COCHRANE CHILD CENTRE/GARDE D'ENFANTS DE COCHRANE, SUCH AS WEATHER CONDITIONS, POWER OUTAGES
- **INTEREST** CHARGES OF 1.25% PER MONTH WILL BE CHARGED ON ANY OVERDUE ACCOUNTS.
- A SERVICE FEE OF $40.00 WILL BE CHARGED ON ALL N.S.F. CHEQUES.
- RECEIPTS WILL BE ISSUED WHEN PAYMENT IS RECEIVED. PLEASE RETAIN THESE RECEIPTS FOR INCOME TAX PURPOSES.
- **ALL** CHILDREN WILL RECEIVE 10 DAYS PER TWELVE MONTH PERIOD FOR VACATION TIME. THESE WILL BE SCHEDULED DAYS OFF WITH AT LEAST TWO WEEKS WRITTEN PRIOR NOTICE. IF TWO WEEKS PRIOR NOTICE HAS NOT BEEN GIVEN THESE DAYS WILL BE CHARGES.
- **ALL** CHILDREN WILL RECEIVE UP TO 5 DAYS PER YEAR FOR SICK DAYS
  THE CENTRE MUST BE CONTACTED BY 8:00 A.M. TO USE THE ALLOTTED 5 DAYS
- **ALL** CHILDREN WILL RECEIVE UP TO 10 DAYS PER YEAR FOR ABSENCES AT A COST OF 50% OF THE CURRENT RATE PROVIDED **THE CENTRE MUST BE CONTACTED BY 8:00 A.M. TO USE THE ALLOTTED 10 DAYS**

All fees are to be paid in advance prior to your child attending. Payment is to be made using HiMama.

Nonpayment, late payment and N.S.F. cheques will be deemed to be a breach of this agreement by the Parent/Guardian, giving rise to the termination of services and withdrawal of the child from the Centre.

STAFF WITNESS SIGNATURE	PARENT/GUARDIAN SIGNATURE
DATE	DATE

Permission to Administer Non-Prescription Medication

Date_____

I hereby give permission to the staff of the Cochrane Child Care Centre Garde d'enfants de Cochrane to apply sunscreen, diaper cream, lip balm, and/or hand sanitizers and any other non-prescription item that is not for acute or symptomatic treatment, whether they have a drug administration number (DIN) or not.

Child's Name: _____

Special Requests or considerations:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Parent or Guardian's Name:

_____

Signature of Parent or Guardian:

_____

COCHRANE CHILD CARE CENTRE

435 Tenth Avenue
Cochrane, Ontario, Canada, P0L 1C0
T: 705-272-4812 | F: 705-272-2718
E: lora.st-pierre@cochraneontario.com

ONTARIO, CA
COCHRANE
WONDERFULLY UNEXPECTED

MEDIA/PHOTOGRAPHY: CONSENT AND RELEASE FORM

COCHRANE CHILD CARE CENTRE

During the year at our Centre there will be many opportunities when pictures will be taken by the Centre staff, the newspaper, etc.

As a parent of a child/children at the Cochrane Child Care Centre, I agree to the following:

- I understand that my child(ren) whose name(s) are listed below may be photographed at the Cochrane Child Care Centre during day to day activities and at special events, field trips or activities.
- I understand that these photographs may be used in newsletters, promotions, displays or in news publications, and social media.

Please be advised that with the numerous electronic devices available, some photographing is beyond our control. We also insist that parents and caregivers refrain from taking photographs at the Centre which include other children.

The following are the names of my child(ren) attending the Cochrane Child Care Centre:

_____

_____

☐ Yes, I confirm that I have read and understood the above, and agree to have my child(ren) photos mounted on the Cochrane Child Care Centre's newsletters, promotions, displays or in news publications and on social media.

☐ No, I do not wish my child(ren) to be a news publication or social media participant.

Name (please print)_____Signature_____

Date_____Witness_____

Participation Agreement

Participation Agreement to email and publish my child's work, photographs or videos via HiMama

To: Parent / Legal Guardian,

Please read this page carefully as it includes information about safety and security issues associated with privacy and behavior. In the interest of safety and security we require parent permission for the publishing of children's work, photographs or videos through a software program called HiMama (the "Program"). By signing this form you grant permission for us to photograph or video your child for the purposes of sharing this information with you through the Program. You will also receive updates and information about your child through the Program to the email you have provided herein. Note that sometimes other children in the center may feature in photos, videos or stories of your child. By giving your consent you agree not to share photos or video of any child, other than your own, outside the Program without permission. To learn more about the Program, please visit www.himama.com. Please complete, sign, and return this form to the center if you wish to participate. We encourage you to contact us if you have any questions. I hereby acknowledge that I wish to voluntarily participate in the Program:

_____

CHILD'S NAME

_____

PARENT/GUARDIAN NAME

_____

EMAIL

_____

PARENT/GUARDIAN SIGNATURE

_____

DATE

Collection of Immunization Data for Children in Daycares

Ontario's Child Care and Early Years Act, 2014 (CCEYA) states that a child care centre must ensure that all children in their centre have complete immunization appropriate to their age **prior** to admission to the child care centre. A record of immunization must be kept as part of each child's record and updated as new immunizations are received.

SECTION A: Complete the following information for your child

Last Name:	First Name:	Date of Birth:
Other Names if Applicable:		Sex:
Address:	City/Town:	Postal Code:
Parent/Guardian's Name:		Home #:
Daycare your child is attending:		Work or Cell #:

SECTION B: Attach your child's immunization record/exemption

☐ If your child has already been vaccinated, please attach a photocopy of your child's immunization record to this form and return to the daycare.

☐ If your child has already completed an exemption under the Child Care and Early Years Act (CCEYA) (two pages), please attach a photocopy of your child's exemption to this form and return to the daycare.

Date:	Parent/Guardian Signature: X

Publicly Funded Immunization Schedule for Ontario

	2 Months	4 Months	6 Months	12 Months	15 Months	18 Months	4-6 Years
DTaP-IPV-Hib* **Diphtheria, Tetanus, Pertussis, Polio, *Haemophilus influenza* type b**	✓	✓	✓			✓	
Pneu-C-13 **Pneumococcal Conjugate 13**	✓	✓		✓			
Rot-1 **Rotavirus**	✓	✓					
Men-C-C* **Meningococcal Conjugate C**				✓			
MMR* **Measles, Mumps, Rubella**				✓			
Var* **Varicella**					✓		
MMRV* **Measles, Mumps, Rubella, Varicella**							✓
Tdap-IPV* **Tetanus, Diphtheria, Pertussis, Polio**							✓

NOTE: Vaccines with an asterisk are required for attendance at daycare and school.

PLEASE RETURN THIS FORM IMMEDIATELY TO YOUR DAYCARE PROVIDER ALONG WITH A COPY OF YOUR CHILD'S IMMUNIZATION RECORD OR EXEMPTION FORM.

Collection of this information is authorized under the Child Care and Early Years Act, 2014 (CCEYA). This information is used to ensure that all appropriate personal care and public health services are provided and the necessary statistics are kept. Questions about this collection should be directed to the daycare operator