



SCHOOL AGE CARE REGISTRATION FORM

Submit completed Application with \$100 Deposit
to the Accounting Office.

Only Applications with Deposits will be processed.

(The deposit will be held in trust to be applied to your last month's fees)

A \$15 payment for the mandatory Comfort Kit is also required.

No spaces are guaranteed until the Deposit is received and
enrollment is confirmed by the program Coordinator.

This program is available to children from Kindergarten
up to 12 years of age.

The School Age Care Coordinator reserves the right to determine
child and program compatibility.

**Priority Registration for September begins March 1st for all
families currently enrolled in the SAC program**

Registration opens to the public April 1st



Child Care Centre

SCHOOL AGE CARE REGISTRATION FORM

The Cridge Centre for the Family collects personal information on this form for reasonable and obvious purposes such as verifying identity, enrolling in a service, to secure contact information, and to meet regulatory requirements. This information will never be used for purposes outside of the obvious without your permission.

Please sign the following statement:

I / we, _____, the parent(s) and/or legal guardian(s) of our child, _____, declare that I / we have read and understand the Centre's Admission Policies and Procedures.

This includes the policy which states, "After a space has been accepted by the parent / guardian and the child is subsequently withdrawn prior to starting in the Centre, a 15% administration fee will be withheld from the original deposit (the balance will be refunded)."

Mother / Guardian: _____

Date: _____

Father / Guardian: _____

Date: _____

----- For Office Use Only -----

Application received on _____ by _____

Start date _____

\$100 Deposit received (to be applied to the last month's fees) by _____

Waitlist (deposit required when space is available and accepted)

ABOUT YOUR CHILD:

Name of child: _____
(last) (first) (middle)

Nickname: _____ Gender: Male () Female ()

Address: _____

Postal code: _____ Care Card # _____

Family Doctor or Pediatrician: _____ Phone: _____

Name of School: _____ Grade: _____

Care required for mornings: () For afternoons: ()

Level of swimming ability: _____

Car seat and Booster seat Legislation in BC (Motor Vehicle Act, Division 36)

Rear and Forward Facing Car Seat Legislation for Younger Children	Booster Seat Legislation for Older Children
Children must ride in a car seat until they are a minimum of 6 years old and a minimum of 40 pounds (18 kg).	Effective July 1, 2008 Children must ride in a booster seat until they are a minimum of 4 feet, 9 inches (145 cm) tall, or a minimum of 9 years old.

To comply with this legislation we are required to collect the following information about your child:

Date of birth: _____ day _____ month _____ year Age _____

Child's height: _____ feet, _____ inches OR _____ cm

Child's weight: _____ pounds OR _____ kg

ABOUT YOUR FAMILY:

Mother	Father
Name: _____	Name: _____
Home phone: _____	Home phone: _____
Cell / Pager: _____	Cell / Pager: _____
Work phone: _____	Work phone: _____
E-Mail: _____	E-Mail: _____
<input type="checkbox"/> I would like to receive communications from The Cridge Centre by email. I understand that I can unsubscribe at any time or change my preferences. I will receive information about the program I am registered in, occasional newsletters, updates and opportunities to participate. Refer to our privacy policy here: https://cridge.org/about-us/annual-reports/	
Place of work/school: _____	Place of work/school: _____
Occupation: _____	Occupation: _____
Work hours: _____	Work hours: _____

Name of sibling(s): _____ Age: _____

_____ Age: _____

_____ Age: _____

Other adults at home: _____

Pets: _____

The Centre's staff will not release your child to an unauthorized person unless you provide us with a **written** permission prior to the event. Therefore, please provide the Centre with at least two emergency contacts, persons who are authorized to drop off and pick up your child.

Emergency Contacts

<u>Name</u>	<u>Relationship to Child</u>	<u>Home Phone</u>	<u>Work Phone</u>	<u>Cell Phone</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

CUSTODY RESTRICTIONS Yes () No ()

If yes, is a copy of the court order or restrictions attached Yes () No ()

Persons not permitted access to child:

<u>Name</u>	<u>Relationship to Child</u>	<u>Phone Number</u>
_____	_____	_____
_____	_____	_____

ABOUT YOUR CHILD'S HEALTH:

Does your child have any **allergies**? Yes () No ()

If "yes", please explain: _____

Are there any special **health concerns or medications** that staff should be aware of? Yes () No ()

If "yes", please explain: _____

You are responsible for keeping a record of your child's immunizations; please attach a copy of the immunization record to this application.

Is your child immunized? Yes () No () If No, please sign the following statement:

I understand that, should there be a suspected or real outbreak of any communicable disease, I must remove my child from the Centre until cleared by medical staff.

Signature: _____ Date: _____

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

First Visit-two months of age: 1"/YY / fvM / UP	Fourth Visit-12 months of age: l'YYY' / \1\1 / liD
<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: YYYYY / . !:vt / DD
<input type="checkbox"/> Meningococcal C ConJugate	<input type="checkbox"/> Diphtheria
	<input type="checkbox"/> Pertussis
Second Visit-two months after first visit: \ ' / YY / \1\1 / rm	<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 In.fluenza Type b (bib)	
<input type="checkbox"/> Hepatitis B	4 to 6 years of age: Yi'YY / \.iVl / DD
<input type="checkbox"/> Pneumococcal Conjugate	<input type="checkbox"/> Diphtheria
	<input type="checkbox"/> Pertussis
Third Visit-two months after second visit: Y Y Y Y / ivl \! / 1)!	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Polio
<input type="checkbox"/> Pertussis	<input type="checkbox"/> Varicella (chickenpox)
<input type="checkbox"/> Tetanus	
<input type="checkbox"/> Polio	Other Immunizations:
<input type="checkbox"/> Haemophilus Influenza Type b (hib)	Y Y i Y / iv \ 1 / DD
<input type="checkbox"/> Hepatitis B	Y Y Y Y / M \ i l DD
<input type="checkbox"/> Pneumococcal ConJugate	Y Y Y Y / M . i / U I I

BY MY SIGNATURE BELOW I ACKNOWLEDGE THE FOLLOWING:

I HEREBY GIVE MY CONSENT FOR A STAFF MEMBER TO CALL A MEDICAL PRACTITIONER OR AMBULANCE FOR MY CHILD IN THE CASE OF ACCIDENT OR ILLNESS, IF I CANNOT IMMEDIATELY BE REACHED.

PARENT/GUARDIAN SIGNATURE _____

DATE _____

CAREGIVER SIGNATURE _____

DATE _____

PERMISSION FORM

1. I hereby give permission for my child to go on field trips arranged by the School Age Care staff. I understand that I will be informed in advance of any field trips that extend beyond their regular hours.

Yes () No ()

2. I hereby give permission to have pictures and/or videos taken of my child in the program setting for general record-keeping and publicity purposes.

Yes () No ()

3. On occasion the Centre receives a request from other professionals or the community to observe the program; we attempt to do this with the least disturbance to the children's routine. I hereby give permission for my child to be present on these occasions.

Yes () No ()

4. At times the staff is invited to partake in a case management meeting or the staff has to confer with other professionals about your child. I hereby give permission for the Cridge Centre staff to confer, if necessary, with the following professionals about my child:

() Physician

() Public Health Nurse

() Social Worker

() School Staff

() Speech and Language
Therapist

() Financial Assistance
Worker

() Physiotherapist

() Occupational Therapist

() ECE Students

5. I hereby give permission for my child to go swimming while attending the program.

Yes () No ()

6. In the event that your child needs medical attention, staff will attempt to contact you or your emergency contact persons. If the staff cannot reach anyone, and your child has to be taken to an emergency clinic, the staff will do so by ambulance, Cridge vehicle or taxi at the Cridge Centre's expense. We will continue to attempt to reach you and your emergency contact persons. I hereby give permission for the Cridge Centre staff to take my child to an emergency clinic.

Yes () No ()

Parent/Guardian Signature

Date

All information about you and your family, which is provided to the Cridge Centre for the Family, will be held in the strictest confidence by all involved departments within the organization.

For more information, please see The Cridge Centre Childcare Policies and the Guidance & Discipline Statement under the Applications link on our Web site: www.cridge.org.



Client Code of Conduct

I understand as a participant in the Cridge Centre for the Family that I am responsible for my behavior.

I will act in ways that bring respect to me, my family and friends and other participants within the program.

I will not use bad language, swear, insult or fight with other people. I will refrain from any form of personal abuse towards others, including verbal, physical and emotional abuse.

I will participate actively in the program.

I will let the organization know if my plans change and I am unable to keep an appointment or participate in an activity.

I will ask any staff or other participants if I may call him or her at home. If he/she agrees, I will be reasonable and responsible about the time of day and how often I call.

I will keep contact with the organization's staff by responding to phone calls, letters and other means of communicating promptly.

If a problem develops, I will immediately talk to my family or caregiver and/or a representative from the organization about it.

If a problem develops within my family or other circumstances occur that affects my participation in the program, I will contact the organization.

I agree to follow all established rules and guidelines of the organization

Date

Signature



Pre-Authorized Credit Card Consent Form

I, _____, hereby authorize The Cridge Centre for the Family to charge the monthly Childcare fees for my child, _____, to my credit card on the 1st of each month.

The regular monthly fee is \$ _____; if my child is enrolled in full-time care for Christmas or Spring break, any additional fees can be added to my monthly charge.

The fees may be adjusted if there is a rate increase (generally effective April 1st annually); no change to the regular monthly rate will be implemented without a minimum of 60 day's notice.

My credit card information:

Client Name: _____

Credit Card type: Visa MasterCard American Express

Credit Card Number: _____ Expiry Date: _____

Name as it appears on the Card: _____

(Card Holder Signature)

(Date Signed)

Please indicate your choice regarding your preferred method of receipt distribution:

- Annual statement (in January) sent to this Email address: _____
- Monthly receipts sent to this Email address: _____
- Monthly receipts mailed to the home address on file

You can return this form to the Accounting Office, or slip it into the payment box in the Childcare lobby.

Please provide an update to the accounting office if your credit card information changes.



Pre-Authorized Debit Consent Form

I, _____, hereby authorize The Cridge Centre for the Family to withdraw the monthly Childcare fees for my child, _____, from my bank account on the 1st of each month.

The regular monthly fee is \$ _____; if my child is enrolled in full-time care for Christmas or Spring break, any additional fees can be added to my monthly withdrawal.

The fees may be adjusted if there is a rate increase (generally effective April 1st annually); no change to the regular monthly rate will be implemented without a minimum of 60 day's notice.

My bank account information:

Bank account type: Chequing Savings

Attach a Void cheque, or complete the following:

Bank Number _____ Transit Number _____

Account Number _____

(Account Holder Signature)

(Date Signed)

Please indicate your choice regarding your preferred method of receipt distribution:

Annual statement (in January) sent to this Email address: _____

Monthly receipts sent to this Email address: _____

Monthly receipts mailed to the home address on file

You can return this form to the Accounting Office, or slip it into the payment box in the Childcare lobby.

Please provide an update to the accounting office if your banking information changes.