

Victoria Kids Out and About REGISTRATION

DATE: Click or tap to enter a date. DATE OF ENROLLMENT: Click or tap to enter a date.

DATE OF LAST DAY: Click or tap to enter a date.

EMAIL(s): Click or tap here to enter text. Click or tap here to enter text.

Childs Information

SURNAME: Click or tap here to enter text. GIVEN: Click or tap here to enter text.

MIDDLE NAME: Click or tap here to enter text. NAME CHILD RESPONDS TO: Click or tap here to enter text.

SEX: M F Other

DATE OF BIRTH: Click or tap to enter a date. PHN: Click or tap here to enter text.

Parent/ Guardian Information

***Please indicate which individual to contact *first*, as well as preferred contact number**

NAME: Click or tap here to enter text. PREFERRED PRONOUNS: Choose an item.

EMPLOYER: Click or tap here to enter text.

WORK PHONE: Click or tap here to enter text. EXT: Click or tap here to enter text.

HOME ADDRESS: Click or tap here to enter text. HOME PHONE: Click or tap here to enter text.
CELL PHONE: Click or tap here to enter text.

Does this child reside with you? Yes No

NAME: Click or tap here to enter text. PREFERRED PRONOUNS: Choose an item.

EMPLOYER: Click or tap here to enter text.

WORK PHONE: Click or tap here to enter text. EXT: Click or tap here to enter text.

HOME ADDRESS: Click or tap here to enter text. HOME PHONE: Click or tap here to enter text.
CELL PHONE: Click or tap here to enter text.

Does this child reside with you? Yes No

Additional Partners/Parents (authorized to pickup)

NAME: Click or tap here to enter text. PHONE: Click or tap here to enter text.

NAME: Click or tap here to enter text. PHONE: Click or tap here to enter text.

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Emergency Contacts

These contacts will be called in an emergency to pickup your child in the event you cannot be reached. Please ensure all emergency contacts bring picture ID with them for verification purposes. Please ensure you have a minimum of two emergency contacts.

NAME: Click or tap here to enter text. PHONE: Click or tap here to enter text.

NAME: Click or tap here to enter text. PHONE: Click or tap here to enter text.

NAME: Click or tap here to enter text. PHONE: Click or tap here to enter text.

Alternate Pickup Information

Persons other than parent/guardian and emergency contacts authorized to pick up child from facility. These people will not be contacted in the event you cannot be reached. Please ensure your alternate pickup brings photo ID for verification purposes. Please list a minimum of 1 alternate pickup.

NAME (relationship): Click or tap here to enter text. PHONE: Click or tap here to enter text.

NAME (relationship): Click or tap here to enter text. PHONE: Click or tap here to enter text.

NAME (relationship): Click or tap here to enter text. PHONE: Click or tap here to enter text.

Persons NOT permitted to Access Child

Please supply a photo of any persons listed. Please note Vic Kids cannot deny parents access to their child without legal documents. You may be asked to provide restraining orders or other legal documents

NAME: Click or tap here to enter text.

NAME: Click or tap here to enter text.

ARE THERE CUSTODY ORDERS? Yes: No: [\(If yes, attach documentation\)](#).

Health, Allergies, and Disabilities

DOES YOUR CHILD HAVE ANY ALLERGIES? Yes: No:

If yes, please list: _____

[\(Please attach special instructions to follow in the event of allergic reaction\)](#)

DOES YOUR CHILD HAVE ANY HEALTH CONCERNS or DISABILITIES? Yes: No:

If yes, please attach documentation or explain: Click or tap here to enter text.

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PLEASE LIST COMMUNICABLE DISEASES OR RECENT ILLNESS YOUR CHILD HAS HAD: Click or tap here to enter text.

Medical Information

FAMILY DOCTOR: Click or tap here to enter text.

PHONE: Click or tap here to enter text.

If you do not have a family doctor, please indicate preferred walk-in medical clinic below:

NAME: Click or tap here to enter text. PHONE: Click or tap here to enter text.

ADDRESS: Click or tap here to enter text.

DO YOU AUTHORIZE THE STAFF AT VIC KIDS TO CALL A PHYSICIAN, TAKE YOUR CHILD TO THE NEAREST EMERGENCY CENTRE, OR SUMMON AN AMBULANCE FOR EMERGENCY SERVICES SHOULD THEY FEEL SUCH SERVICES ARE REQUIRED? **Yes:** **No:**

If the emergency is not time sensitive, you will be notified prior to calling an ambulance. If it is time sensitive will be notified as soon as possible. You are responsible for any costs incurred.

Basic Schedule and Record of Immunization

Please attach immunization record, or record dates below:

First Visit- 2 months of age Click or tap to enter a date.	Second Visit- 2 months after 1 st Click or tap to enter a date.	Third Visit- 2 months after 2 nd Click or tap to enter a date.
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Diphtheria
<input type="checkbox"/> Haemophilus Influenza Type B (hib)	<input type="checkbox"/> Haemophilus Influenza Type B (hib)	<input type="checkbox"/> Haemophilus Influenza Type B (hib)
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Meningococcal C Conjugate	<input type="checkbox"/> Pertussis	<input type="checkbox"/> Pertussis
<input type="checkbox"/> Pertussis	<input type="checkbox"/> Pneumococcal Conjugate	<input type="checkbox"/> Pneumococcal Conjugate
<input type="checkbox"/> Pneumococcal Conjugate	<input type="checkbox"/> Polio	<input type="checkbox"/> Polio
<input type="checkbox"/> Polio	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Tetanus		
Fourth Visit- 12 months of age Click or tap to enter a date.	Fifth Visit- 12 months after 3 rd Click or tap to enter a date.	Sixth Visit- 4 to 6 years of age Click or tap to enter a date.
<input type="checkbox"/> Meningococcal C Conjugate	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Diphtheria
<input type="checkbox"/> Measles	<input type="checkbox"/> Haemophilus Influenza Type B (hib)	<input type="checkbox"/> Pertussis
<input type="checkbox"/> Mumps	<input type="checkbox"/> Pertussis	<input type="checkbox"/> Polio
<input type="checkbox"/> Rubella	<input type="checkbox"/> Pneumococcal Conjugate	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Varicella (Chicken Pox)	<input type="checkbox"/> Polio	<input type="checkbox"/> Varicella (Chicken Pox)
	<input type="checkbox"/> Tetanus	
	<input type="checkbox"/> Measles, Mumps, Rubella	

Other Immunizations:

Please list: Click or tap here to enter text. Date: Click or tap to enter a date.

Please list: Click or tap here to enter text. Date: Click or tap to enter a date.

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Delay or Refusal of Vaccination

At Victoria Kids Out and About we respect and support all families with their decision to vaccinate, delay vaccination, or refuse vaccination for their child.

In the event there is an outbreak of a communicable disease that your child has not been vaccinated for, we will immediately inform you as the parent/guardian. Your child may be refused care due to communicable disease outbreak in the daycare or community if Vic Kids feels it is in your child's, or other children's, best interest. Victoria Kids Out and About cannot be held liable or responsible in the event your child contracts any of the viruses listed on the vaccine form. We will do our best to keep your child safe at all times in the event of an outbreak.

By signing below, I confirm I have made the choice not to vaccinate my child and understand the implications that may have on my child's attendance at Vic Kids. I also understand Vic Kids is not liable should my child contract a vaccine preventable illness.

Name: [Click or tap here to enter text.](#) Signature: _____
Date: [Click or tap to enter a date.](#)

Previous Care

HAS YOUR CHILD BEEN IN CARE (Sunday school, preschool, etc.) BEFORE? Yes No

If yes, where? _____

May we contact them? Yes No

If no, please explain: _____

Do you think your child is comfortable leaving parents? Yes No

Other Children at Home

NAME (relationship): _____ DATE OF BIRTH: _____

NAME (relationship): _____ DATE OF BIRTH: _____

NAME (relationship): _____ DATE OF BIRTH: _____

Care Agreement

Please indicate what days you require care: Mon Tue Wed. Thur. Fri.

Please indicate what times you require for drop off: [Choose an item.](#)

Timeslot availabilities are dependant on ratios and not approved until signed by manager.

Manager Name: [Click or tap here to enter text.](#) Signature: _____

Date: [Click or tap to enter a date.](#)