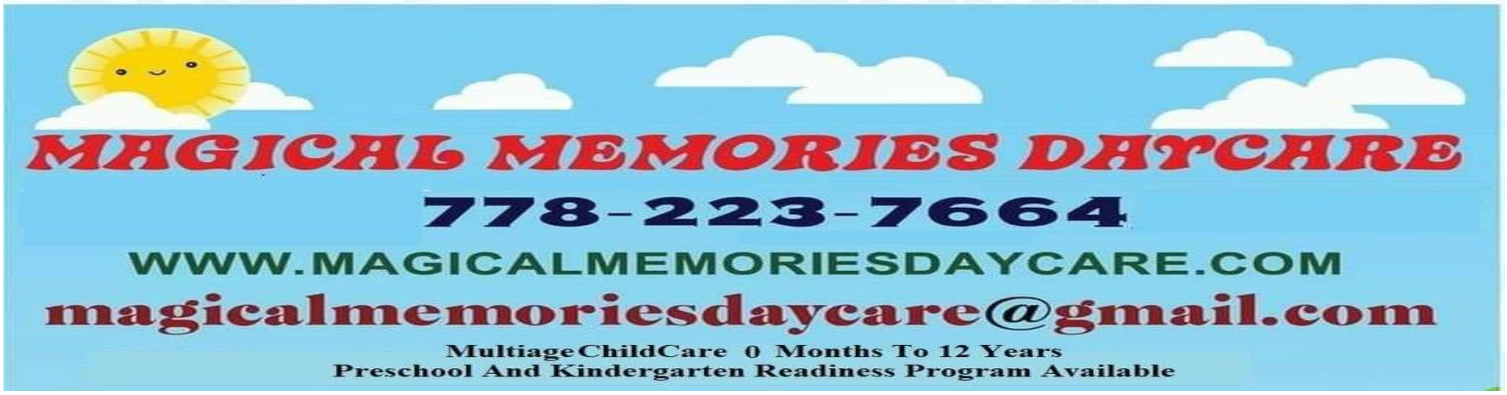
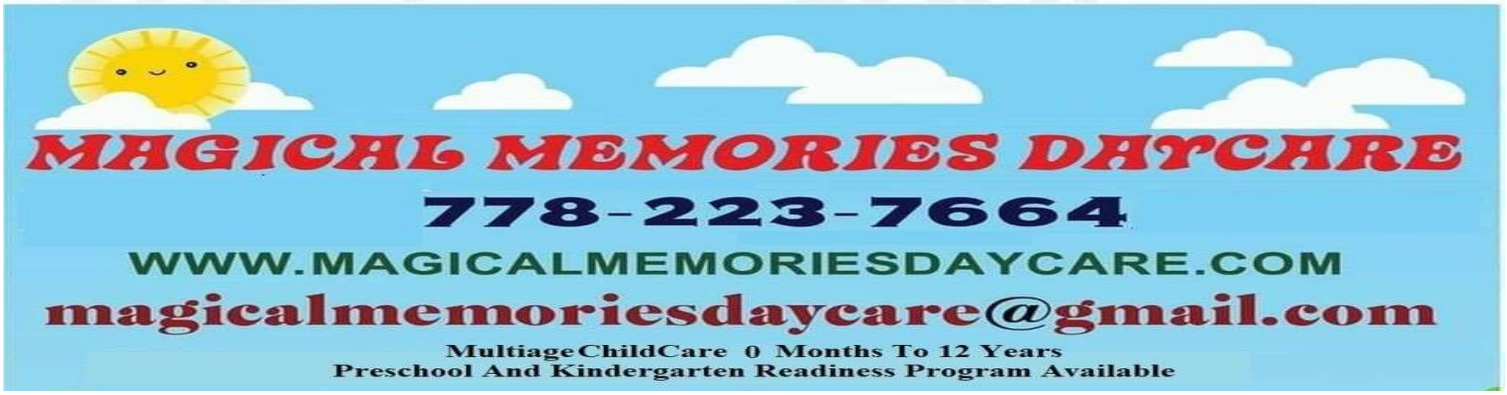


FACILITY NAME: MAGICAL MEMORIES DAYCARE	CHILD'S PHOTO
FULL NAME OF CHILD: _____ USUAL NAME OF CHILD [IF DIFFERENT]: _____	

Personal Information		
CHILD'S D.O.B:	GENDER: F / M	STARTING DATE:
ADDRESS:	POSTAL CODE:	
	PHONE: ( )	
PARENT OR GUARDIAN:		PARENT OR GUARDIAN:
ADDRESS [IF DIFFERENT FROM ABOVE]:		ADDRESS [IF DIFFERENT FROM ABOVE]:
PHONE:		PHONE:
WORK ADDRESS/ALTERNATE LOCATION:		WORK ADDRESS/ALTERNATE LOCATION:
PHONE [INCLUDE LOCAL]:		PHONE [INCLUDE LOCAL]:



CELLULAR/PAGER:	CELLULAR/PAGER:

HOURS AT THIS LOCATION:	HOURS AT THIS LOCATION:

Emergency Health Information			
CARE CARD NUMBER:			
FAMILY DOCTOR/CLINIC NAME:		FAMILY DENTIST/CLINIC NAME:	
ADDRESS:	PHONE:	ADDRESS:	PHONE:

Consent for Emergency Care	
I authorize the staff at the childcare centre to call a medical practitioner or ambulance in the case of accident or illness of my child(ren) if the parent cannot immediately be reached.	
SIGNATURE OF PARENT/GUARDIAN:	DATE:
MANAGER OF FACILITY:	

Person(s) Authorized to Pick Up Child (Other than parent/guardian listed above)		
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

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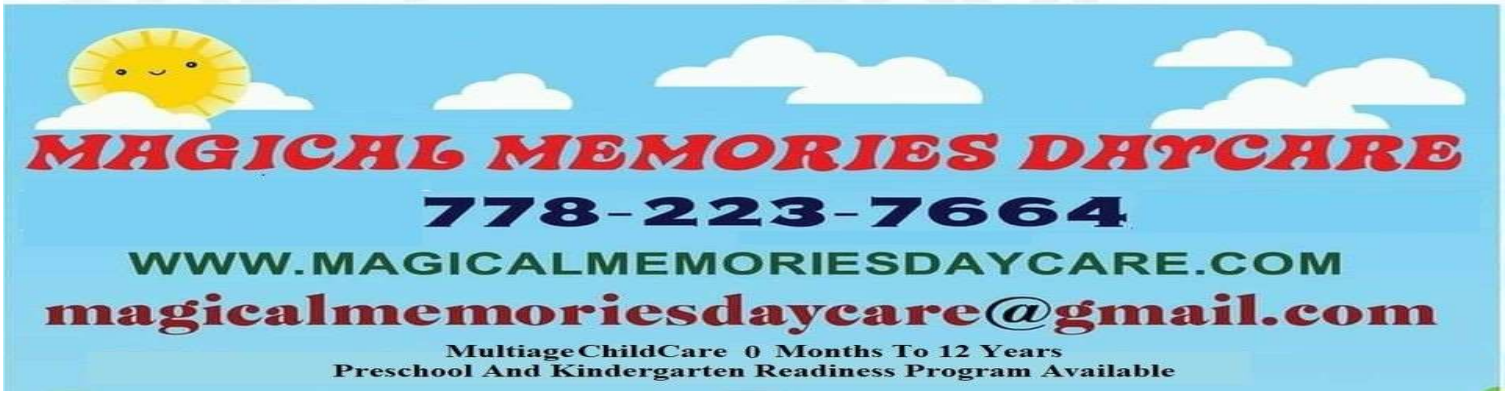
magicalmemoriesdaycare@gmail.com

Multiage ChildCare 0 Months To 12 Years
Preschool And Kindergarten Readiness Program Available

Persons(s) not Authorized to Pick Up Your Child		
NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

Custody Agreement:	☐ YES ☐ NO
IF YES, PROVIDE A COPY OF THE CUSTODY ORDER TO THE FACILITY MANAGER/LICENSEE	



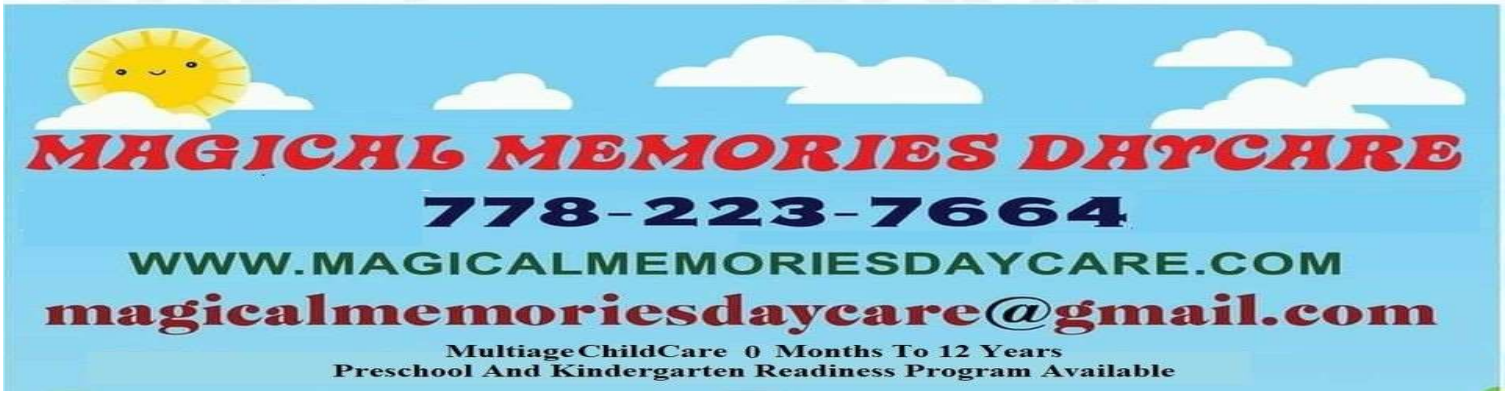
Child's Immunization Status

(Please record dates [year/month/day] or attach copy of immunization)

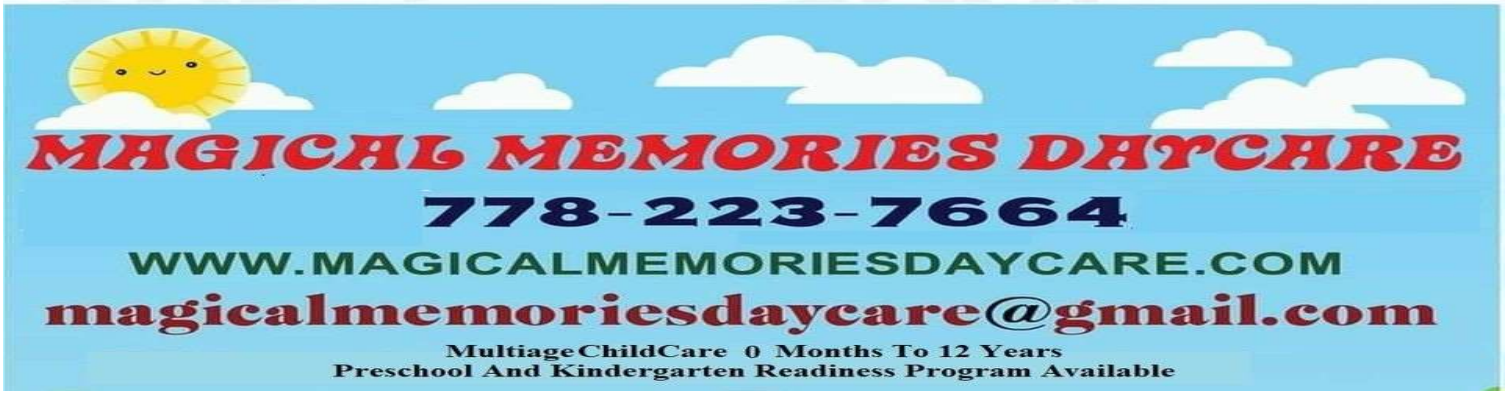
IS YOUR CHILD UP TO DATE ON IMMUNZATIONS? ☐ YES ☐ NO ☐ NOT IMMUNIZED

DIPHTHERIA	PERTUSSIS	TETANUS	POLIO	MMR (Measles/Mumps/Rubella)	HIB
1.	1.	1.	1.	1.	1.
2.	2.	2.	2.	2.	2.
3.	3.	3.	3.		
4.	4.	4.	4.		
5.	5.	5.	5.		

COMMENTS:



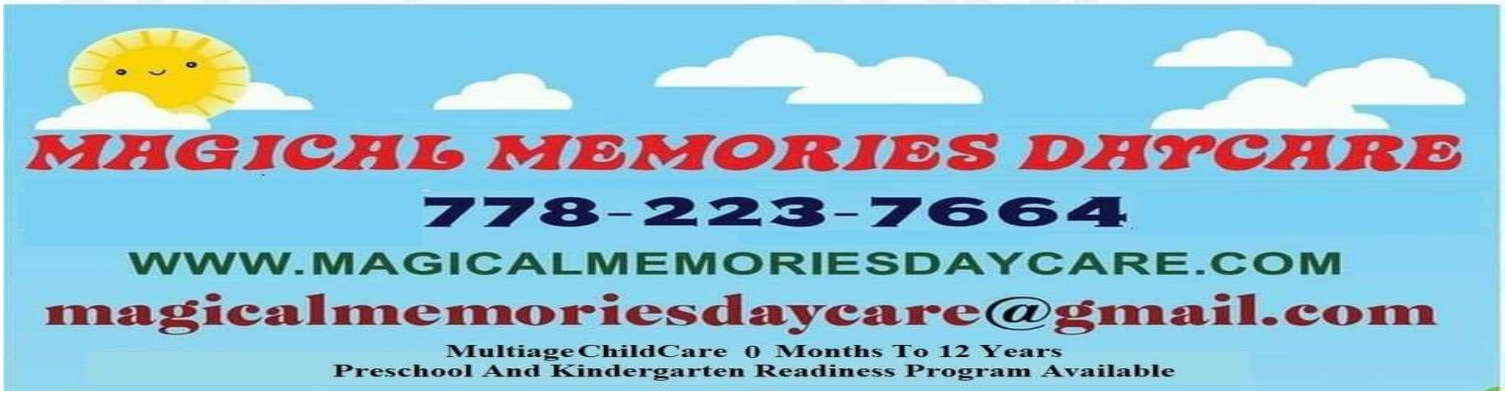
Health Information [Please attach a separate sheet, if necessary]
REGULAR MEDICATION[S] AND REASONS FOR [PLEASE LIST]:
ALLERGIES AND TREATMENT OF [PLEASE LIST]:
INJURY(S), ILLNESS(ES) OR OPERATIONS YOUR CHILD HAS HAD AND INCLUDE DATE(S): a) Please describe any concerns/issues regarding your child's health (seizures, asthma, vision, hearing, etc.) b) Please describe any concerns you may have regarding your child's development [i.e., behaviour, vision, hearing, speech, language, mobility, etc.]: c) Describe any specific care instruction regarding a) and/or b):
OTHER HEALTH CARE PROFESSIONALS INVOLVED IN YOUR CHILD'S LIFE, E.G., OCCUPATIONAL THERAPIST/PHYSICAL THERAPIST:



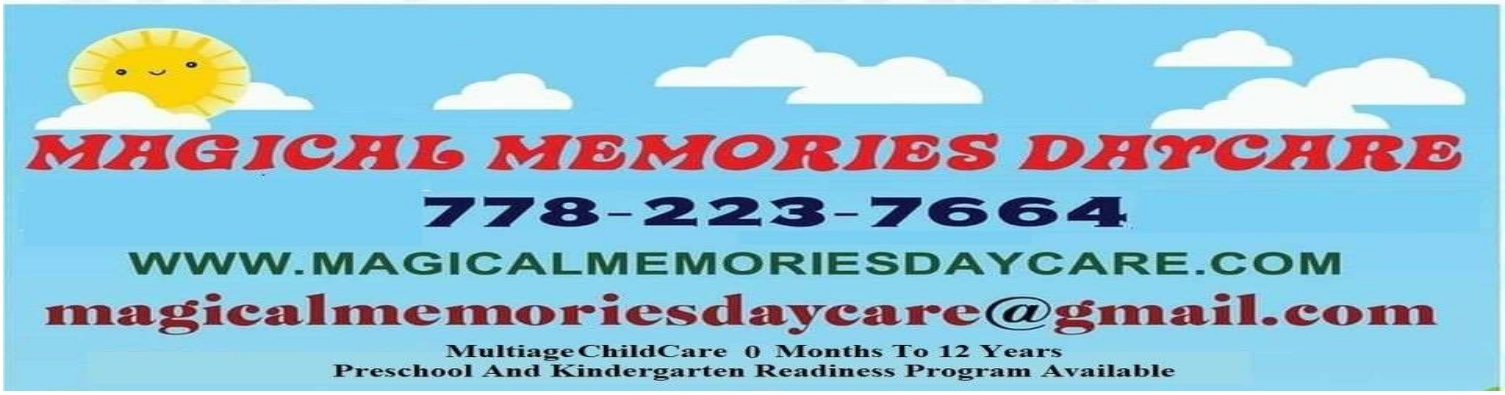
Group Experiences
WHAT IS/ARE YOUR CHILD'S FAVOURITE TOY(S)/ACTIVITIES:
HAS YOUR CHILD HAD PREVIOUS PLAY GROUP EXPERIENCE? ☐ YES ☐ NO IF YES, HOW DID HE/SHE ADAPT?
HOW DOES YOUR CHILD BEHAVE TOWARD OTHER CHILDREN [E.G., SEEKS OTHERS OUT, FEELS SHY]?

Emotional
HOW DOES YOUR CHILD REACT WHEN LEFT WITH UNFAMILIAR PEOPLE AND/OR IN UNFAMILIAR SITUATIONS?
DOES YOUR CHILD HAVE ANY PARTICULAR FEARS? PLEASE DESCRIBE:
WHAT SUGGESTIONS DO YOU HAVE THAT WOULD HELP STAFF MAKE YOUR CHILD'S TRANSITION INTO THIS PROGRAM EASIER?
Family and General Household Information
PLEASE LIST THE NAMES OF THE SIGNIFICANT PEOPLE IN YOUR CHILD'S LIFE [E.G., SIBLINGS, GRANDPARENTS, ETC.]:
PLEASE DESCRIBE THE GUIDANCE AND DISCIPLINE METHODS USED AT HOME:

PRIMARY LANGUAGE SPOKEN IN THE HOME:	OTHER LANGUAGES:

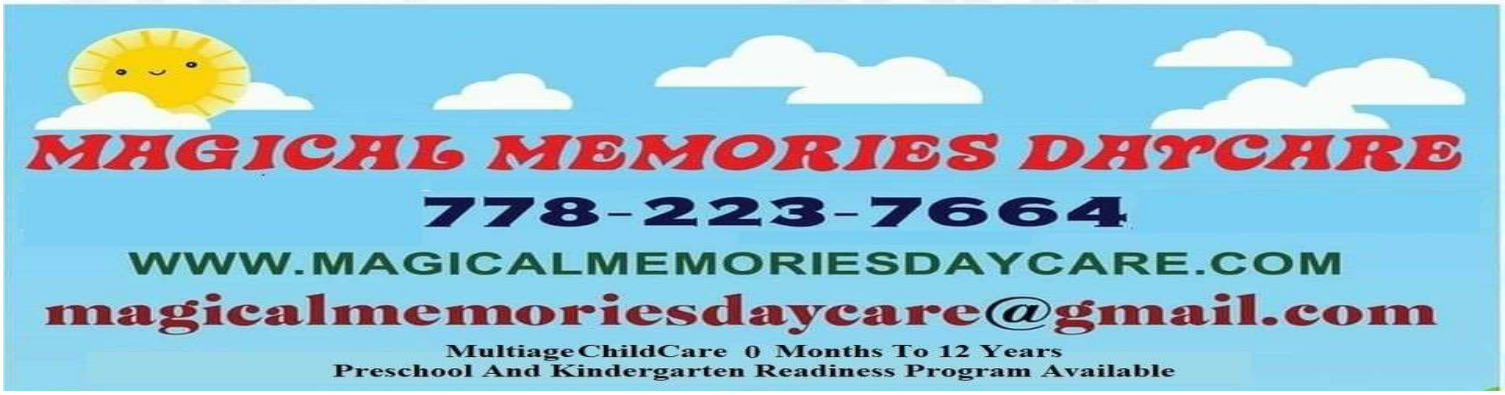


EATING AND NUTRITION		
LIST YOUR CHILD'S FAVOURITE FOOD:		
LIST ANY DISLIKED FOOD:		
PLEASE DESCRIBE ANY PARTICULAR EATING PATTERNS:		
ARE THERE ANY RELIGIOUS OR ETHNIC OBSERVANCES RELATED TO FOODS:		
SLEEPING		
NAP TIME:	HOW LONG TO SETTLE	TIME OF WAKING:
BEDTIME:	HOW LONG TO SETTLE	TIME OF WAKING:
IS YOUR CHILD A DEEP SLEEPER, OR DOES (S)HE AWAKEN EASILY?		
DOES YOUR CHILD TAKE A FAVOURITE COMFORTER [E.G., TOY]? ☐ BLANKET ☐ OR TO BED? YES / NO IF YES, PLEASE DESCRIBE AND TELL US IF IT IS "NAMED":		
WHAT IS YOUR CHILD'S MOOD UPON WAKENING?		
TOILETING		
IS YOUR CHILD TOILETTRAINED? ☐ YES ☐ NO ☐ PARTIALLY		
PLEASE INDICATE YOUR CHILD'S FREQUENCY OR PATTERNS FOR BOWEL MOVEMENTS:		



DESCRIBE ASSISTANCE NEEDED FOR TOILETING:
WHAT "SPECIAL" WORD DOES YOUR CHILD USE FOR: URINATION: _____ BOWEL MOVEMENTS _____
Any Other Comments

Signature of Parent or Guardian Providing Information		
SIGNATURE:	PRINT NAME:	DATE:



NOTE: This information may be reviewed by Fraser Health Authority Licensing staff as per legislation.

Facility Use Only		
Staff person reviewing family's documents:		
SIGNATURE:	PRINT NAME:	DATE:
CHILD'S WITHDRAWAL DATE:	REASON FOR WITHDRAWAL:	

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Registration Form for Child Care

Alternate Care Provider Permission Form Parent/Guardian

The Child Care Licensing Regulation, Section 17 requires that:

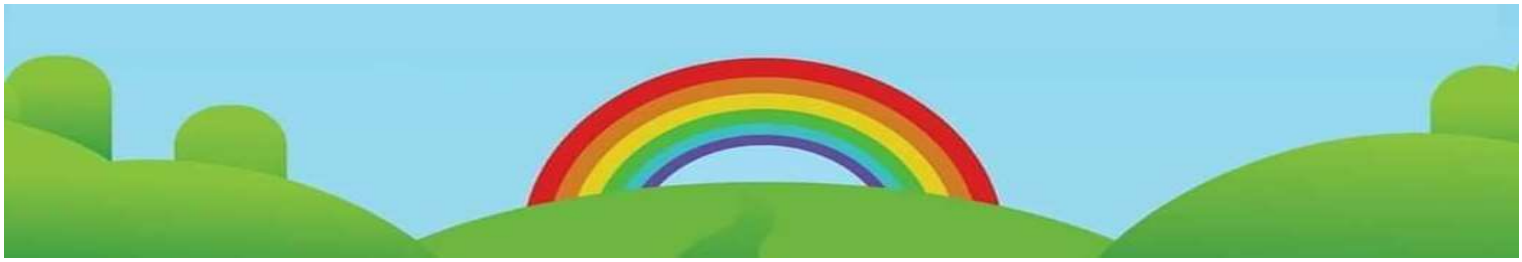
I hereby give my permission to SANOBER MUSHARAF (Licensee) to leave my child(ren) in care of the below noted alternate caregiver(s) when required.	
The following adult(s) have been designated by the Licensee of MAGICAL MEMORIES Childcare Facility as alternate caregiver(s): To be completed by Licensee:	
Name:	Relationship:
Name of Parent (print):	Date:
Signature of Parent:	

Staffing

17 (4) If a responsible adult is absent from a community care facility, the licensee must appoint an educator, an assistant, or another responsible adult to assume the responsibilities of the absentee.

To qualify for employment in a facility as a responsible adult, a person must:

- be of good character
- have reached 19 years of age.
- be able to provide care and mature guidance to children.
- either have completed a course on the care of young children or have relevant work experience Should your childcare provider choose to use an alternate care provider, written



parent/guardian permission to leave the child(ren) in the care of the alternate care provider is required. In addition, an alternate care provider is required to have a criminal record check, immunization status, medical clearance and an approved first aid certificate.

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Registration Form for Child Care

To be completed by Parent:

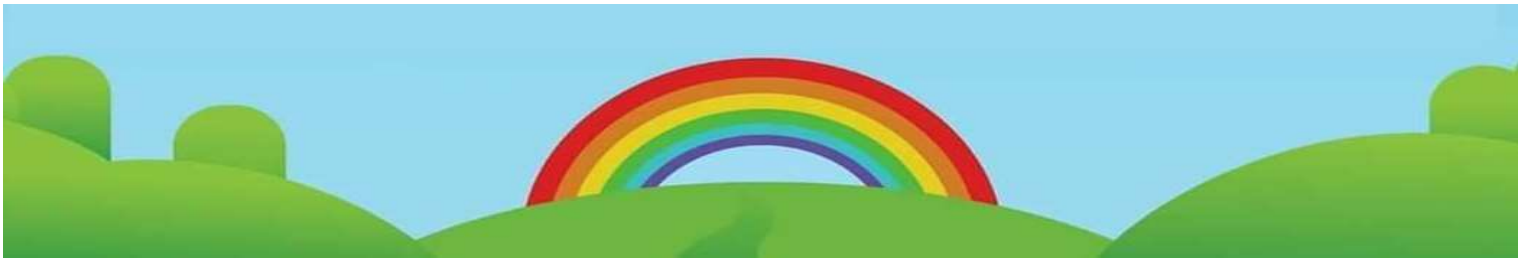
Administration of Medication Consent Form

Child's Name		
Physician Name:		Phone:
Pharmacy Name:		Phone:
Medication:		Prescription#:
Dosage of Medication:	HAS THIS MEDICATION BEEN ADMINISTERED TO THIS CHILD PREVIOUSLY? ☐YES ☐ NO IF NO, HAS CHILD RECEIVED MEDICATION FOR 24 HRS PRIOR TO RETURNING TO THE CHILD PROGRAM? YES ☐ NO ☐	
Last Time to be given by Parents:		
How many times to be given by care provider:		
ANY POSSIBLE SIDE EFFECTS THAT YOU HAVE BEEN MADE AWARE OF BY THE PHYSICIAN OR PHARMACY?		

I hereby give permission and authorize _____ to administer the medication in the dosage as stated above. This dosage is consistent with the recommendations of the Physician and/or drug manufacturer. I accept the responsibility of supplying the current correct medication in its original container, and I agree to submit a new consent form if there is any change in the medication to be administered.

_____ _____ _____

Signature of Parent/Guardian Date Phone



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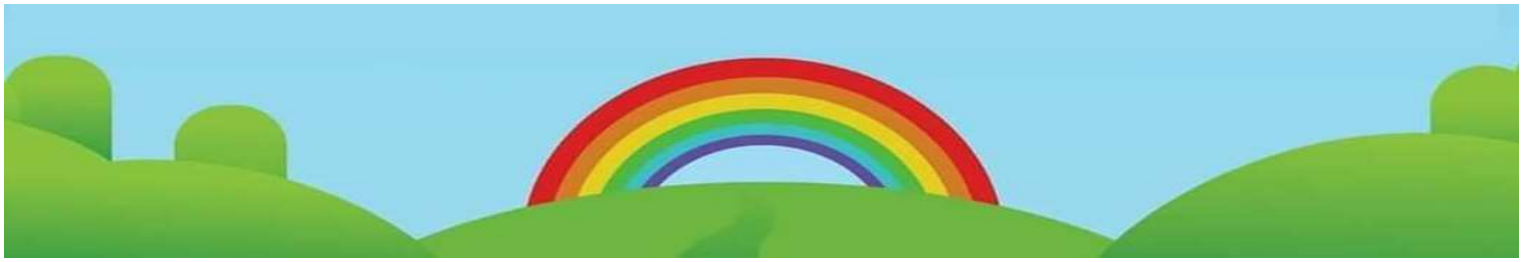
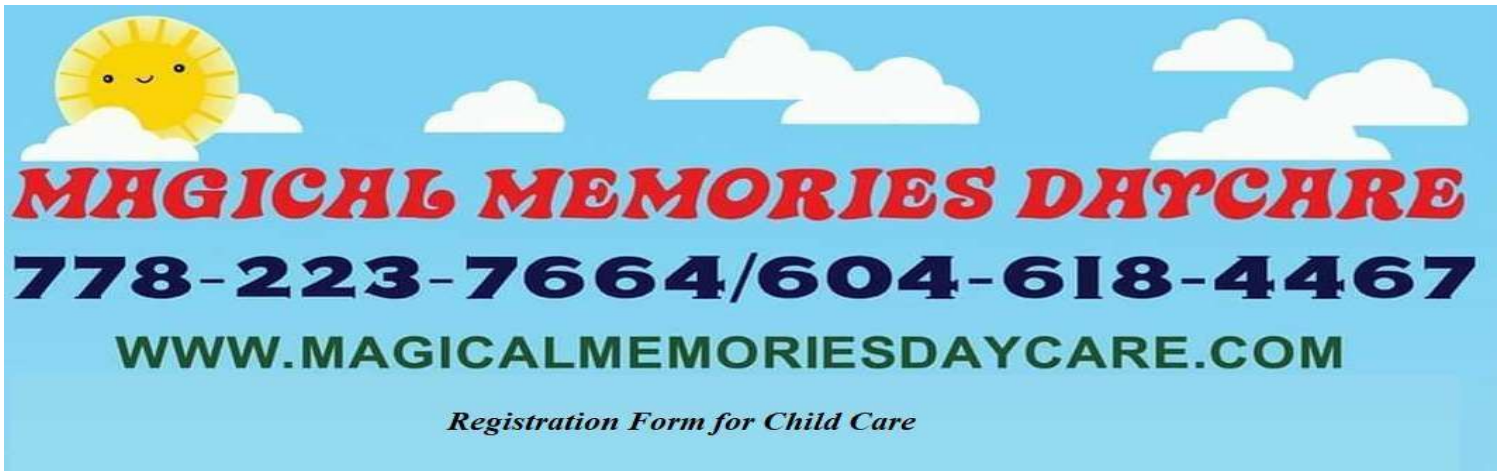
Registration Form for Child Care

Caregiver's Administration Record:

DATE:	TIME GIVEN:	AMOUNT GIVEN:	ADMINISTERED BY:

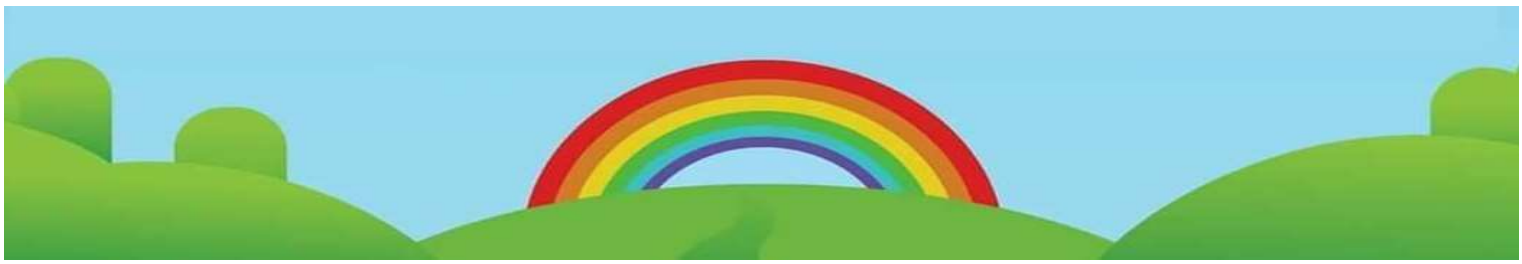




CARE PLAN

Facility Name:	MAGICAL MEMORIES DAYCARE
Child's Name:	
Child's DOB	
Date:	
Assessment- Diagnosis the current statement:	
Goals- What need to be accomplished:	
Action Plan- The steps need to be Taken:	
Review: When will the Care Plan be reviewed:	

PARTICIPANTS IN THIS PLAN RELATIONSHIP TO CHILD	SIGNATURE:



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Registration Form for Child Care

Contract and Rate Agreement:

Child's name: _____Sex: F___ M___ Date of Birth_____
Custodial Parent's name(s) _____
Childcare services will begin on _____, 2024.
The hours for care will begin at _____AM to ____ PM on the following days:

Mon, Tues, Wed, Thurs, Fri *(circle them)*

If your child is going to be absent or late, please call-in advance.

Childcare will not be available on all statuary holidays and the following holidays Eid -al Fitr & Eid al Adha.

My vacation period will be paid according to the yearly calendar. You will be responsible for making other childcare arrangements.

$ _____per month for full time care. (Please circle one of following option below according to your child age)

(Age 0 – 11 months, Age 12 – 36 months, Age 3 to kindergarten, Age Kindergarten To 12 Years / Out of School Care)

A parent who picks up their child after the scheduled pick-up time will be charged a late fee of $10.00 for every 15 minutes late.

Childcare fees are payable in advance and are due no later than 5th of each month. Non-Refundable Registration of $ 150

Childcare will collect an advance deposit of $ 50 at the time of enrollment. This amount will be returned when services are terminated if your account is paid in full OR amount will be deduct in the case of late pick up.

Fees may be (or may not be) adjusted when services are not available because of illness or vacation.

Childcare fees will be paid by: Cash _____ E-Transfer: _____ (sanober_nq@hotmail.com)

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Notice: A two-week written notice is required for any of the following:

1. Termination of the agreement by either party
2. Increases in childcare fees.
3. Vacation periods for both families and provider.
4. For the return of your advance deposit

Agreement signed by: _____ Name: _____

License Signatures: _____ Name: _____

Date: _____

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QUIET TIME AGGREMENT FORM:

Children whose parents have chosen quiet time will have an opportunity to be quiet for 30 minutes. Children will be expected to be in their own space, which may be on a mat or designated area. During this time, they may listen to quiet music or stories or a video. After 30 minutes of quiet time alone, the children may play quietly with activities that will not wake the other children.

PARENT'S CHOICE

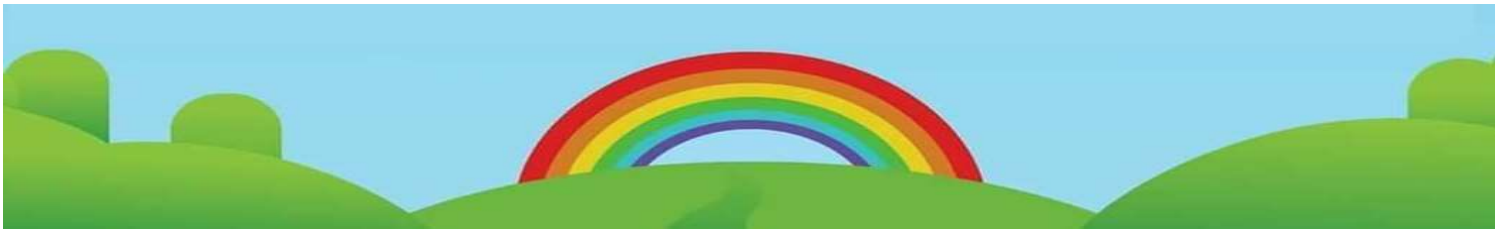
I want my child_____ to have:

- ☐ NAP TIME _____MINS,
- ☐ ☐ QUIET TIME _____MINS,
- ☐ REST TIME_____MINS.

ANY SPECIFIC INSTRUCTIONS:

PARENT'S SIGNATURE: _____DATE: _____

(For more details, please see the policy page No.17)



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WALKS & FIELD TRIPS CONCENT FORM

We often we take trips away from my home to help your child learn more about the community. Your permission is needed to allow your child to ride in my car. You will be notified in advance when trips are being planned to indicate the date, location, and amount of time away from home.

A proper infant seat or child booster seat is required for car travel for any child under the age of 8.

____You or ____I will provide the seat.

Your signature below provides your permission for me to provide this service.

Parents Signature: _____

Date: _____

(For more details, please see policy page No.18)

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Registration Form for Child Care

PHOTO RELEASE FORM

Photo Release Form I hereby permit photographs taken of my child/children at the Stowe Free Library, or activity sponsored by the Stowe Free Library, to be used by the daycare in its publications, press releases, display cases, and website to document and promote the value and use of the library products and services.

Date: _____ Name:

_____

Address: _____

Phone: _____

Names of Children: _____

Under the Age of 16: _____

Please Check Option: May be identified by FULL name: _____

May be identified by First name ONLY: _____

May NOT be identified by name: _____

Signature of parent or Guardian: _____

(For more details, please see Policy page No. 20)

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Registration Form for Child Care

TRANSPOTATION CONCENT FORM

I provide limited transportation services upon request. Your permission is needed to allow your child to ride in my car. Your signature below provides your permission for me to provide this service.
_____ (Parent initials)
A proper infant seat or child booster seat is required for car travel for any child under the age of 8.
_____You or _____I will provide the seat.
Please provide a current photograph of your child in case it is needed in an emergency.
I (We) fully understand and agree to the terms of this contract. This agreement may be re-negotiated at any time.
Parent's Signature _____Date _____
Parent's Name in Print _____
Provider's Signature _____ Date _____
Provider's Name in Print_____

(For more details, please see policy page No.28)

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Registration Form for Child Care

ACTIVE PLAY POLICY AGGREMENT

Monitoring and review
The active play and physical activity policy from page No. 44 to 46 will be monitored by educators, staff, management, and the licensing office. It will be implemented as part of the daycare's policy.

All 3 pages viewed and signed by: _____ Date:_____

(For more details, please see policy page No. 44 to 46)

SCREEN TIME POLICY AGGREMENT

I, _____understands that TV and other screen time can get in the way of playtime, physical activity, and interactions with others, which all contribute to learning and healthy physical/social development.

Parents Signature:_____

Date: _____

(For more details, please see policy page No. 47)

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An annual revision of these policies, a new contract will be signed by all families each year. We reserve the right to make changes in rates and policies as we deem necessary. Parents will be notified, in writing, of any changes that may occur. Any event or agreement with between Magical Memories Daycare and Parent not mentioned in the policy will be settled on separate agreement NOT overriding our policy. Every attempt will be made to give at least two weeks' notice of changes.

Accepted by:

Parents or Guardians Signature: Manager/Licensee Signature:

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