



# YMCA of Medicine Hat

## Before & After School Care Registration Form

Site (please list name of school where child will be attending): \_\_\_\_\_  
 \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child's Address: \_\_\_\_\_

Parent/Guardian (Primary)	Parent/Guardian (Secondary)
Name: _____	Name: _____
Date of Birth: _____	Date of Birth: _____
Address: _____	Address: _____
Postal Code: _____	Postal Code: _____
Telephone: _____ (h/c) _____ (w)	Telephone: _____ (h/c) _____ (w)
Employer: _____	Employer: _____
Address: _____	Address: _____
Postal Code: _____	Postal Code: _____
E-mail: _____	E-mail: _____
<small>*required for program communication &amp; updates</small>	<small>*required for program communication &amp; updates</small>

### ALTERNATE PERSON TO CONTACT IN CASE OF EMERGENCY:

Please provide names of individuals who are available to assist when an emergency occurs and we cannot reach you.

1. Name: \_\_\_\_\_  
 Address (include pc): \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Work Place: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
 Work Address (include pc): \_\_\_\_\_

2. Name: \_\_\_\_\_  
 Address (include pc): \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Work Place: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
 Work Address (include pc): \_\_\_\_\_

Please list individuals (ages 16 or older) who you authorize to pick your child up from the program:

- Name: \_\_\_\_\_ Telephone: \_\_\_\_\_
- Name: \_\_\_\_\_ Telephone: \_\_\_\_\_
- Name: \_\_\_\_\_ Telephone: \_\_\_\_\_
- Name: \_\_\_\_\_ Telephone: \_\_\_\_\_



**KINDERGARTEN CHILD PROFILE INFORMATION**

Names and ages of other children in your family:

1: \_\_\_\_\_ 3: \_\_\_\_\_

2: \_\_\_\_\_ 4: \_\_\_\_\_

Is your child toilet trained? \_\_\_\_\_ Require Assistance? \_\_\_\_\_

Has your child been in child care before? \_\_\_\_\_

If yes, please comment about your child's experience while in care?  
\_\_\_\_\_  
\_\_\_\_\_

Is your child is right handed? \_\_\_\_\_ left handed? \_\_\_\_\_

Please comment on anything that may impact the care of your child, so we may ensure your child is comfortable.

1. Known fears or anxiety?  
\_\_\_\_\_

2. Foods that your child will refuse to eat: \_\_\_\_\_

3. Separation from parents - how does your child handle saying good-bye?  
\_\_\_\_\_

4. Anything you would like us to know about your child:  
\_\_\_\_\_  
\_\_\_\_\_

5. Describe the goals you would like to set for your child:  
\_\_\_\_\_  
\_\_\_\_\_



**MEDICAL DATA**

Child's Name: \_\_\_\_\_ AHC #: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Physician Address: \_\_\_\_\_

\_\_\_\_\_

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**HEALTH INFORMATION**

Please explain if your child has experienced any of the following:

Immunization current:  YES  No

If no, explain why \_\_\_\_\_

\_\_\_\_\_

a) Allergies

EpiPen/Twinject \_\_\_\_\_ Inhaler/Puffer \_\_\_\_\_

Food/Medication/Animals \_\_\_\_\_

b) Reoccurring medical problems: (ie: RSV, chronic ear infection, roto virus, asthma, etc.)

\_\_\_\_\_

c) Seizures: \_\_\_\_\_

d) Medical Dietary Problem: \_\_\_\_\_

e) Please list any communicable diseases your child has had: \_\_\_\_\_

\_\_\_\_\_

f) Does your child have any special needs or disabilities? (i.e.: speech, hearing, daily medication.) Please explain:

\_\_\_\_\_

\_\_\_\_\_



**GRADES 1 – 6 CHILD PROFILE INFORMATION**

Names and ages of other children in your family:

1: \_\_\_\_\_ 3: \_\_\_\_\_

2: \_\_\_\_\_ 4: \_\_\_\_\_

Has your child been in Before & After School care before? \_\_\_\_\_

If yes, please comment about your child's experience while in care? \_\_\_\_\_  
\_\_\_\_\_

Please comment on anything that may impact the care of your child, so we may ensure your child is comfortable.

6. What interests does your child have?  
\_\_\_\_\_

7. What types of physical activities you're your child prefer?  
\_\_\_\_\_

8. Does your child have any behavioral concerns? If so, how do you respond?  
\_\_\_\_\_

9. Anything you would like us to know about your child:  
\_\_\_\_\_  
\_\_\_\_\_

10. Describe the goals you would like to set for your child:  
\_\_\_\_\_  
\_\_\_\_\_



*I have received, read, understood, and agree to abide by the above terms. I understand that a Parent Handbook outlining the program's policies and procedures will be provided to me prior to September 1<sup>st</sup>.*

\_\_\_\_\_  
Parent/Guardian #1 Signature Date \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian #2 Signature Date \_\_\_\_\_

\_\_\_\_\_  
Site Director Signature Date \_\_\_\_\_

Agreed Hours of Attendance: \_\_\_\_\_

Commencement Date: \_\_\_\_\_ Fees: \_\_\_\_\_

Applying for Provincial Subsidy: \_\_\_\_\_

Site Director: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_

**Return completed forms by email to your school's Site Director.**

**Note: During the 2018 summer months, completed forms can be emailed to:**

**Victoria Potter, Before & After School Care Program Manager  
victoria.potter@medicinehatymca.ca**

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