Preschool Enrolment Form

Child's Name _____

Age _____ Birthday _____

Address _____ Postal Code _____

Contact Info:

Parent/Guardian 1:

Name _____

Home Phone _____

Cell Phone _____

Work Phone _____

Address Work _____

E-mail _____

Parent/Guardian 2:

Name _____

Home Phone _____

Cell Phone _____

Work Phone _____

Address Work _____

E-mail _____

Emergency Contact 1:

Name _____

Phone _____

Emergency Contact 2:

Name _____

Phone _____

Physician:

Name _____

Phone _____

Address _____

_____

Email _____

Office Use Only

Enrolment Start Day: _____ Enrolment End Day: _____

Other:

Preschool Programs

Half Day Program (9:00 am – 12:00 pm) *Please circle days attending*

Monday Tuesday Wednesday Thursday Friday

Extended Day Program (9:00 am – 2:25 pm) *Please circle days attending*

Monday Tuesday Wednesday Thursday Friday

Full Day Program (9:00 am – 4:00 pm) *Please circle days attending*

	Monday	Tuesday	Wednesday	Thursday	Friday
Extended Care		□ 7:45 am – 8:30 am			
		□ 4:00 pm – 5:00 pm		□ 5:00 pm – 6:00 pm	

Diapers	□ YES	□ NO
Naps	□ YES	□ NO

Play Loft Preschool Camps

□ **Part-Time (9:00 am – 12:00 pm)** □ **Extended (9:00 am – 2:25 pm)**
□ **Full-Time (9:00 am – 4:00 pm)**

Winter Camp (Dec. 30th – January 03rd 2020) *Please circle days attending*

Monday Tuesday Wednesday Thursday Friday

March Break Camp (March 16th – March 20th 2020) *Please circle days attending*

Monday Tuesday Wednesday Thursday Friday

□ Half Day (9 am – 12 pm) or (1 pm – 4 pm): $ 190 /wk or $ 50 /day
□ Extended Day (9 am – 2:25 pm): $ 270 /wk or $ 70 /day + $ 30 (Lunch Cost)
□ Full Day (9 am – 4 pm): $ 340 /wk or $ 80 /day + $30 (Lunch Cost)

**** Please note a minimum 3 day sign up is required***

Your Child's Health

Is your child anaphylactic? *(Please Circle)* YES NO

Do they have an auto-injector *(Please Circle)* YES NO

Are you concerned that your child may be prone to any type of allergies? *Please describe*

Does your child have any medical conditions of which we should be made aware?

Has your child had the following common childhood Illnesses? *(Please Select)*

Does your child have problems with any of these?

☐ Constipation
☐ Convulsions
☐ Diarrhea
☐ Fainting Spells
☐ Frequent Colds
☐ Frequent Ear Infections
☐ Skin Rash

Has your child had any of these diseases?

☐ Asthma
☐ Bronchitis
☐ Chicken Pox
☐ Diabetes
☐ Heart Disease
☐ Mumps
☐ Measles

Does your child have any speech, hearing or visual problems?

Would there be any restriction to play or activities?

Are there any food restrictions?

What language(*s*) are spoken at home?

Are there any other comments or information you would like to let us know about?

Play Loft Authorization for Child Pickup

We would like to remind all parents of Play Loft's policy regarding the safe pick-up of children other than the parent or legal guardian. As a measure of security, we require prior written notification from parents authorizing the person(s) picking up your child(ren) from school, either on a regular or occasional basis.

To this effect, by signing this form, parents will inform Play Loft of the person(s) allowed to pick-up their child(ren) for the current school year only.
In the event of an unforeseen emergency situation, whereby a different person other than those listed on the Authorization Form will be picking up your child, we ask that a parent telephone Play Loft as soon as possible to apprise us of this situation. Play Loft's policy is such that we will not allow someone to leave with a child without prior notification from the parents. The safety of your child is of utmost importance and we know that you, as parents, will understand the reasons for this policy.

If there is a legal custody, access, restraining order or judgment that Play Loft should be made aware of, please indicate this in the appropriate check-box below and provide instructions for our staff on the back of this form. We thank you in advance for your cooperation in this important matter.

Name of Persons	Relationship to Child	Telephone (home/work)

_____ _____

Signature of Parent/Guardian Date

_____

Printed Name of Person Signing

PARENT LUNCH PROGRAM AND DIET REQUEST FORM

By signing this document, I_____am acknowledging that I have read and understood Play Loft's No Lunch Bag Policy and agree for my child to participate in the catered lunch program offered at Play Loft.

DIETARY PRACTICE

☐ Kosher ☐ Halal ☐ No Red Meat ☐ Chicken ☐ Fish ☐ Other_____
VEGETARIAN: ☐ Lacto-Ovo ☐ Ovo ☐ Lacto ☐ Vegan ☐ Other _____

DOCTOR'S NAME:_____DIAGNOSIS: _____
DIET DURATION: ☐ TEST ☐ TEMPORARY ☐ PERMANENT

FOOD ALLERGY OR INTOLERANCE

Symptoms of exposure: _____
Severity of symptoms: ☐ MILD ☐ MODERATE ☐ SEVERE ☐

ANAPHYLAXIS

FOODS ALLERGY:

PROTEIN: ☐ LEGUMES ☐ EGG ☐ FISH ☐ MEAT ☐ OTHER _____
MILK PROTEINS: ☐ ALL ☐ OTHER _____
VEGETABLES: ☐ TOMATO ☐ ALL ☐ FRESH ☐ COOKED ☐ OTHER _____
FRUIT: ☐ CITRUS ☐ OTHER _____
GRAIN PRODUCTS: ☐ WHEAT ☐ OTHER _____

PREFERRED ALTERNATIVES:
FOOD INTOLERANCE: ☐ LACTOSE ☐ GLUTEN ☐ MSG ☐ NICKEL ☐ OTHER _____

TOLERATED FOOD:_____
THERAPEUTIC DIET: _____
DIET PATTERN: ☐ ENCLOSED

ADDITIONAL COMMENTS:

PARENT/GUARDIAN NAME	PARENT/GUARDIAN SIGNATURE	DATE
SUPERVISOR NAME	SUPERVISOR SIGNATURE	DATE

Ontario

Ministry of Education

Statement of Conscience or Religious Belief for Child

Child Care and Early Years Act, 2014

Affidavit

I, _____,
(Last Name, First Name)

parent of the following named child:

Last Name	First Name	Date of Birth (yyyy/mm/dd)

Home Address

Unit Number	Street Number	Street Name

City/Town	Province	Postal Code

Child Care Centre / Home Child Care Agency

_____

make oath or solemnly affirm and say as follows:

1. Immunization conflicts with my sincerely held religious or conscious convictions.
2. I make this affidavit for the purposes of complying with the requirements of subsection 35(2) of Ontario Regulation 137/15 under the *Child Care and Early Years Act, 2014*, and for no other or improper purpose.

SWORN OR SOLEMNLY AFFIRMED before me

at _____
(Municipality/First Nation)

in _____
(Province)

on _____
(Date (yyyy/mm/dd))

_____
Parent of Named Child Signature

_____
Signature of Commissioner for Taking Affidavits

_____
Type or Print name if signature is illegible (Last Name, First Name)

Personal information on this form is provided to your child care provider as required under subsection 35(2) of Ontario Regulation 137/15 under the *Child Care and Early Years Act, 2014*. The information may be collected and used by the Ministry of Education in the course of confirming compliance with that subsection. The information may also be collected and used by the Medical Officer of Health pursuant to clause 72(6)(a) of Ontario Regulation 137/15 under the *Child Care and Early Years Act, 2014* in order to support the health and well-being of children. Questions about this collection should be directed to: Manager, Licensing and Compliance, Ministry of Education, 77 Wellesley Street West, Box 980, Toronto ON M7A 1N3, or by calling the Child Care Licensing Help Desk at 1-877-510-5333.

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Ontario Ministry of Education

Statement of Medical Exemption for Child

Child Care and Early Years Act, 2014

Notice of Collection of Personal Information

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Section 1 – Child Information

Last Name	First Name	Date of Birth (yyyy/mm/dd)

Home Address

Unit Number	Street Number	Street Name

City/Town	Province	Postal Code

Child Care Centre / Home Child Care Agency

Section 2 – Declaration of Regulated Health Professional

I, _____ , certify that,
(Name of Regulated Health Professional) (Last Name, First Name)

for medical reasons indicated below, the above named child should be exempted from the requirements of Ontario Regulation 137/15 under the *Child Care and Early Years Act, 2014*.
The specific reasons and length of exemptions are checked in the boxes below.
The time periods for temporary medical exemptions are indicated.

Disease	Immunity		Contraindication	Length of Exemption			
	Clinical diagnosis of prior disease	Laboratory confirmation of immunity or prior disease	Detrimental to health	Permanent	Temporary	From (yyyy/mm/dd)	To (yyyy/mm/dd)
Diphtheria			☐	☐	☐	/	
Tetanus			☐	☐	☐	/	
Pertussis			☐	☐	☐	/	
Poliomyelitis			☐	☐	☐	/	
Meningococcal Disease			☐	☐	☐	/	
Measles		☐	☐	☐	☐	/	
Mumps		☐	☐	☐	☐	/	
Rubella		☐	☐	☐	☐	/	
Haemophilus Influenza Type B (Hib)	☐	☐	☐	☐	☐	/	
Varicella	☐ *	☐	☐	☐	☐	/	

*Clinical diagnosis of prior varicella or herpes zoster disease is acceptable for varicella immunity.

Use this space to define evidence of immunity.

Use this space for explanations of contraindications detrimental to health.

Section 3 – Signature

Name of Regulated Health Professional (Last Name, First Name)	Registration or Licence Number

Business Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Signature of Regulated Health Professional	Date (yyyy/mm/dd)

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