9280 No.2 Road, Richmond, BC V7E 2C8
(604)277-1079
Info@tapestryearlylearning.com

April 29, 2019

Dear Parents/Guardians,

Thank you for choosing Tapestry Christian Early Learning! Enclosed, you will find the Registration Package for the 2019 Summer Camps.

Registration is on a first come, first serve basis, with all required information complete.

When registering please ensure you have included the following:

- ☐ All forms completed and signed
- ☐ Camp fee (cheque payable to Tapestry Christian Early Learning)
- ☐ Copy of current immunization record (if child does not currently attend TCEL)
- ☐ Copy of birth certificate (if child does not currently attend TCEL)
- ☐ 2 Current photos of child (if child does not currently attend TCEL)

If you have any questions, or need assistance in completing the registration package, please feel free to speak with Victoria Chan, Program Director.

Sincerely,

Victoria Chan

Program Director

Tapestry Christian Early Learning

Student start date: ____________

TAPESTRY CHRISTIAN EARLY LEARNING
2019 SUMMER CAMP REGISTRATION FORM

Personal Information

Child's Name: ______________________________ DOB: ______________
First Middle Surname dd/mm/yyyy

Name child responds to: ____________________ Gender: M ______ F ______

Address: ____

City: ______________ Postal Code: __________ Phone: ______________

Child's First Language: ____________ Child's Second Language:(dialect)____________

Adult(s) with whom child lives with: ______________________________

LEGAL GUARDIAN(S)

Name: ______________________________ Relationship: ______________

Phone: (home) ____________(work) ____________ (cell) ______________

E-Mail Address: ____

Name: ______________________________ Relationship: ______________

Phone: (home) ____________ (work) ____________ (cell) ______________

E-Mail Address: ____

ALTERNATIVE PERSON(S) TO CALL IN CASE OF EMERGENCY

Name: ______________________________ Relationship: ______________

Phone: ________________ Language(s) Spoken: ______________________

Name: ______________________________ Relationship: ______________

Phone: ________________ Language(s) Spoken: ______________________

PERSON(S) AUTHORIZED TO PICK-UP CHILD (Include Legal Guardians)

Name: ______________ Relationship: ______________ Phone: __________

Name: ______________ Relationship: ______________ Phone: __________

Name: ______________ Relationship: ______________ Phone: __________

Name: ______________ Relationship: ______________ Phone: __________

Is there a custody agreement ________ Yes_______ No. If yes please supply us with a copy of the agreement.

Emergency Health Information

Care Card Number: ______________________ Date of Last Tetanus Shot: __________________

Doctor: ____ Phone: ____________________

Dentist: ____ Phone: ____________________

Immunization Record on file with Richmond Health Department? Yes______ No______

Does your child have:

A medical condition/concern? YES NO

If yes, please provide further information:

____

Allergies? YES NO (If yes, please complete Allergy Medical Form and attach)
If yes, please provide further information:

____

Asthma? YES NO (If yes, please complete Asthma Medical Form and attach)
If yes, please provide further information:

____

Has your child had a seizure in the past year? YES NO
If yes, please provide further information:

____

Does your child require a special diet related to a medical condition? YES NO
If yes, please provide further information:

____

Food sensitivities? YES NO
If yes, please provide further information:

____

List all prescription and "over the counter" medications your child receives:

Medication	Times Given	Reason for Medication
________________________	______________________	________________________
________________________	______________________	________________________
________________________	______________________	________________________

Does your child require extra support from Supported Child Development, Speech Language Pathologist, Occupational Therapist or other agencies? YES NO

If yes, please provide further information:

____

PLEASE READ CAREFULLY, CHECK BOXES AND SIGN BELOW

Child born in: ☐ 2014 ☐ 2015 ☐ 2016

Please indicate your camp preference below:

Program	Dates & Time	Cost
Week 1 (Art & Science)	☐ August 6th – 9th (9:00am – 12:30pm)	$80
Week 2 (Music & Movement)	☐ August 12th – 16th (9:00am – 12:30pm)	$100
Week 3 (Outdoor Adventure)	☐ August 19th – 23rd (9:00am – 12:30pm)	$100

Please initial each box below:

☐ I understand that fees are due upon registration

☐ I understand that I must give one week's written notice before the first day of the camp to receive a full refund of camp fees. 50% of the camp fees will be refunded if withdrawal notice is given less than one week before the first day of camp. No refunds will be given if withdrawal notice is given on or after the first day of camp.

☐ I verify that my child will be 3 years of age and fully toilet-trained at the beginning of the camp

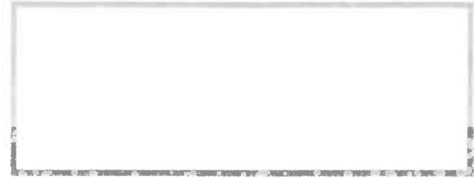
☐ I have read and understand all the information provided in the Tapestry Christian Early Learning Sumer Camp Parent Handbook that can be found on TCEL's website (www.tapestryearlylearning.com) under admissions

I agree and understand the registration policies and procedures.

Parent/Guardian Signature ________________________________**Date**______________

Vancouver Coastal Health
Promoting wellness. Ensuring care.

IMMUNIZATION (VACCINATION) INFORMATION FOR CHILDCARE



Dear Parent/ Guardian:

All childcare facilities in BC are required by law under the *Community Care and Assisted Living Act* to keep a record of each child's immunization history. These records are required to be made available to Vancouver Coastal Health Authority (VCH) medical health officers for public health programs. The information you provide on this form will be used to update your child's health record at VCH in order that: medical health officers may respond if a disease outbreak occurs in your childcare facility; public health staff can recommend immunizations which your child may be missing; and VCH is able to provide better care to your child as part of its public health programs. **Please complete and return this form to your childcare facility.**

PART A: CHILD AND FAMILY INFORMATION

PLEASE PRINT CLEARLY

Childcare facility ____________________

Child's name ____________________ (Surname) ____________________ (Given Name) ____________________ (Preferred Name)

Sex: M F Birthdate ____ / ____ / ____ (dd / mm / yyyy) ____________________ (Place of birth)

Child's personal health number (Care Card) ____________________

Home address ____________________ Postal code __________ Home phone __________

Father's Name ____________________ (Surname) ____________________ (Given Name) Daytime phone __________

Mother's Name ____________________ (Surname) ____________________ (Given Name) Daytime phone __________

Guardian's Name ____________________ (Surname) ____________________ (Given Name) Daytime phone __________

Doctor's name ____________________ Doctor's phone __________

PART B: CHILD'S VACCINATION INFORMATION

Attach a photocopy of your child's vaccination record OR complete the following record.

Has your child had chickenpox disease after one year of age? ☐ Yes ☐ No

Children who have not had the chickenpox vaccine or disease after 1 year of age need the vaccine.

VACCINES	DATES GIVEN							
	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy	dd/mm/yyyy
DIPHTHERIA								
TETANUS								
PERTUSSIS (WHOOPING COUGH)								
HEPATITIS B								
POLIO								
HAEMOPHILUS INFLUENZAE TYPE B (HIB)								
MENINGOCOCCAL CONJUGATE								
PNEUMOCOCCAL CONJUGATE								
MMR (MEASLES, MUMPS, RUBELLA)								
MEASLES (RUBEOLA)								
RUBELLA (GERMAN MEASLES)								
MUMPS								
HPV (HUMAN PAPILLOMAVIRUS)								
VARICELLA (CHICKENPOX)								
LIST OTHER VACCINES								

Please attach child's photo to this form

Tapestry Christian Early Learning

CHILD CARE EMERGENCY CONSENT FORM

CHILD'S NAME: ______________________________ BIRTHDATE: ____________________

SURNAME, FIRST NAME(S) YEAR/MONTH/DAY

ADDRESS: ____

PARENT'S NAME: ______________________________ HOME PHONE: ____________________

CELL PHONE: ______________________________ WORK PHONE: ____________________

PARENT'S NAME: ______________________________ HOME PHONE: ____________________

CELL PHONE: ______________________________ WORK PHONE:____________________

EMERGENCY CONTACT: ________________ CELL PHONE: ____________ PHONE: ____________

OUT OF TOWN CONTACT: ______________________________ PHONE: ____________________

CHILD'S DOCTOR: ______________________________ PHONE: ____________________

DATE OF MOST RECENT TETANUS SHOT:______________________________

ALLERGIES / MEDICATIONS: ______________________________

CHILD'S DENTIST: ______________________________ PHONE: ____________________

CARE CARD NUMBER______________________________

____________ ______________________________

DATE SIGNATURE OF PARENT / GUARDIAN

CONSENT

1) It is the policy of this facility to notify a parent when a child is ill or needs medical attention. Occasionally we cannot contact parents and we need to get immediate help for the child. Our procedure is to call for an ambulance.

2) Please sign the consent below so that we can take the appropriate action on behalf of your child. Return the signed consent to the facility immediately. We will take this consent with us to the emergency centre.

3) I hereby give consent for my child ______________________________ to be taken to the nearest emergency centre when I cannot be contacted.

4) I hereby give consent for my child named above to receive medical treatment.

____________ ______________________________

DATE SIGNATURE OF PARENT / GUARDIAN

REQUEST FOR ADMINISTRATION OF MEDICATION

Name of Facility:________________________________ Date:________________________

Child's Name:_________________________________ Birthdate:_____/_______/_______

Medication to be prescribed by a physician and/or non prescription medication provided by the parent – in the original container labelled with the child's name/dosage/time.

Parent or Guardian:_____________________________ Phone #'s: _________________________

Physician's Name: _____________________________ Phone: ____________________________

Name of Medication: ___________________________ Prescription Number:_________________
(located on vial or bottle for prescription medications)

Medication is in the form of: Pills ☐ Drops ☐ Cream ☐ Other ☐ ______________________

Dosage: __________________________________ Time: ________________________________

Reason for Medication: ____
____

Additional Comments: (possible reactions, consequences of missing medication, medication to be given with, etc.)

____
____
____
____

I hereby give permission for the staff to administer the above named medication to my child according to the orders and instructions I have provided. I agree to notify the staff and complete a new request form if there are any changes to the medication or instructions.

Signature of Parent/Guardian ____________________________ Date:______________________

RECORD OF MEDICATION ADMINISTERED

Date Commenced: ___________________ **Date Stopped:** ________________________

DATE	TIME	DOSAGE	COMMENTS	STAFF SIGNATURE

*Please use a separate form for each medication or refill.
*Please ensure unused medication is returned to the parent/guardian.

Life Threatening Allergy Emergency Action Plan

Child's Name: ____________________

Child's Full Name:

Date of Birth:

Parent/Guardian:

Phone (home): Phone (work):

Emergency Contact:

Phone (home): Phone (work):

Primary Care Provider: Office Phone:

Picture ID

CHILD'S ANAPHYLAXIS TRIGGERS ARE:

☐ Food (list): ____________________

☐ Insect stings (list): ____________________

☐ Other: ____________________

ANYONE HAVING AN ANAPHYLACTIC REACTION MIGHT HAVE ANY OF THESE SYMPTOMS "F.A.S.T.":

Face: Hives, itchy eyes, itchy nose, flushed/red face, swelling of face, lips or tongue

Airway: Difficulty breathing, swallowing or speaking, coughing or choking, change of voice, sneezing, nasal congestion

Stomach: Stomach pain, vomiting, diarrhea

Total Body: Hives, itching, swelling, weakness, dizziness, lightheadedness, loss of consciousness, anxiety, feeling of doom

CHILD'S EMERGENCY TREATMENT:

☐ Medication is stored where?

☐ Epinephrine auto-injector – expiry date:

☐ Field Trip Plans:

DO NOT WAIT FOR SYMPTOMS TO GET WORSE OR NEW SYMPTOMS TO BEGIN

- **GIVE EPINEPHRINE**
- **CALL 911**
  - Specify "allergic reaction" & that epinephrine has been given by auto-injector
  - Provide location & telephone number
  - Centre name: ____________________
  - Centre address: ____________________
  - Centre phone #: ____________________
- **Keep child lying down with feet elevated; if unconscious or vomiting, put in side-lying position.**
- **CALL PARENTS**
- **Always send child to hospital after receiving epinephrine**

Epinephrine is the first line medication which should be used for the emergency management of a person having a potentially life threatening allergic reaction.

Antihistamines (e.g. Benadryl ™) and asthma medications should not be used instead of epinephrine for treating anaphylaxis.

It is the parent's responsibility to notify the facility of any change in the child's condition.

Sign below if you agree with above information & plan:

____________________ Parent/Guardian ____________ Date

____________________ Child Care Staff ____________ Date

Asthma Emergency Action Plan for ____________ year

Child's Name: ______________________________ **Age:** ________

Centre Name: ____________________ **Centre Address:** ______________________________

Child's Full Name: ______________________

Date of Birth: ______________________

Parent/Guardian: ______________________

Phone (home/cell): ____________ Phone (work): ____________

Emergency Contact: ______________________

Phone (home): ____________ Phone (work): ____________

Health Care Provider: ____________ Office Phone: ____________

Picture ID

CHILD'S ASTHMA TRIGGERS ARE:

☐ change in temperature ☐ colds, infection ☐ dust, mites ☐ emotion (e.g. upset) ☐ mould ☐ physical activity ☐pollen

☐ animals (list): ______________________

☐ foods (list): ______________________

☐ strong smells (list): ______________________

☐ Other: ______________________

CHILD'S ASTHMA SYMPTOMS ARE USUALLY:

☐ appears anxious

☐ coughing

☐ difficulty talking

☐ fast/shallow breathing

☐ pale

☐ hunched over

☐ short of breath

☐ wheezing

☐ in-drawing/tracheal tug

☐ other (list below):

☐

☐

CHILD'S EMERGENCY TREATMENT:

☐ Medication is stored:

☐ Medication expiry date:

☐ Field Trip Plans:

- **GIVE** ______________________
  (Name of medication)
- **Follow Instructions:**

____

____

____

____

____

____

____

____

____

- **If unsure, child is worse, or not getting better CALL 911**
- **CALL PARENTS**

It is the parent's responsibility to notify the facility of any change in the child's condition.

Sign below if you agree with above information & plan:

______________________ ____________
Parent/Guardian Date

______________________ ____________
Child Care Staff Date

CARE PLAN

Child's Name: ____________________ Date of Birth: ________________ Age ______ years ______ months

Program: ____________________ Attendance (days/times in program): ____________________

Parent or Guardian	Relationship	Contact Information

Other Professionals Involved (note if current or previous, and the capacity of involvement)

Professional/Organization	Contact Person	Contact Information	Capacity of Involvement

Rationale for Care Plan (Describe Child's Needs): ____________________

Recommendations from other professionals (attach any relevant documents or add comments below): ____________________

	Description	Person(s) Responsible	Date for Review
Staffing Requirements Reg. 19 (3), 34 (1)			
Adaptations/ Modifications to the Environment Reg. 13 (4), 58 (i)			
Adaptations/ Modifications to Program (activities/ routines) Reg. 58 (ii) 3(c) 44 (2)			
Dietary Requirements Reg. 58 (3)(a) 48(1)(2) 57(h)			
Medication Reg. 58 (3)(a), 57 (2)(e)(f)(h) 53 (1)(2)(3)(4)			
Health & Safety Requirements/ First Aid Reg 58(i) 23(1)			
Behavioural Guidance Reg. 58 (3)(d) 51 (2)			

Records on File Reg. 56(1)(2)(3 ______________________________

Parent/Guardian	Date	Parent/Guardian	Date
Supervisor/Child Care Staff	Date	Manager	Date

TAPESTRY
CHRISTIAN EARLY LEARNING

PHOTO & VIDEO RELEASE

I give permission for Tapestry Christian Early Learning to take pictures or videos of my child, ____, during school, special events or field trips. I understand that these photos or videos may be used in promotional materials such as brochures, flyers or on the preschool websites. Students or staff may also take photos for professional development assignments.

NO CHILD'S NAME WILL BE PUBLISHED

Please check your choice below.

☐ I give permission for my child to be photographed or video taped.

☐ I do not give permission for my child to be photographed or video taped.

______________________________ ______________________
Parent's Signature Date