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(604)277-1079  
Info@tapestryearlylearning.com

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February 1, 2020

Dear Parents/Guardians,

Thank you for choosing Tapestry Christian Early Learning! Enclosed, you will find the Registration Package for the 20120/2021 school year.

Tapestry Christian Early Learning will continue to offer enrolment for children ages 3-5 years of age. We have a full program (M-F 9:00am to 3:30pm) and a variety of part-time programs as listed in our registration package. If your preferred days are full, you may choose to be placed on the waitlist.

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
- \$50 Non-refundable registration fee
- 1 Current month's cheque and post-dated cheques to pay for 1 month in advance (August 1, 2020-May 1, 2021)
- Copy of current immunization record
- Copy of birth certificate
- 2 Current photos of child

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

Sincerely,

Gyssel Romano

Program Director

Tapestry Christian Early Learning



Student start date:  
\_\_\_\_\_

**TAPESTRY CHRISTIAN EARLY LEARNING  
2020/2021 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:             2016             2017             2018

Please indicate your class preference below:

Program	Days	Time
<b>Full Program</b>	<input type="checkbox"/> Monday /Tuesday/Wednesday/Thursday/Friday	9:00am - 3:30pm
<b>Morning</b>	<input type="checkbox"/> Monday /Wednesday/Friday <input type="checkbox"/> Tues/Thursday	9:00am – 12:30pm
<b>Full Day</b>	<input type="checkbox"/> Monday /Wednesday/Friday <input type="checkbox"/> Tuesday/Thursday	9:00am – 3:30pm

Please indicate the corresponding payment schedule as shown below:

Program	Cost
<input type="checkbox"/> Full Program: M-F (9:00am to 3:30pm)	\$825.00 per month
<b>Morning program:</b>	
<input type="checkbox"/> M/W/F AM only (9:00am-12:30 pm)	\$320.00 per month
<input type="checkbox"/> T/TH AM only (9:00am-12:30pm)	\$210.00 per month
<b>Full-day program:</b>	
<input type="checkbox"/> M/W/F full day (9:00am-3:30pm)	\$540.00 per month
<input type="checkbox"/> T/TH full day (9:00am-3:30pm)	\$390.00 per month
<b>Drop In Fees (based on availability):</b>	
Morning only (9:00am – 12:30pm)	\$30.00
Afternoon only (12:30pm – 3:30pm)	\$25.00
<i>*Note: you must be in session in the morning to add this drop-in option</i>	
Full Day (9:00am – 3:30pm)	\$50.00

**Where did you hear about us?**

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**Please initial each box below:**

I understand that a payment of \$50.00 is due upon registration for Administration fees, and my spot will not be held until this fee is received.

I understand that tuition fees are due one month in advance, on the first of each month, from August 2020 to May 2021. **Post-dated cheques are required.**

I am aware that I must give **60 days written notice** before the first day of the calendar month to withdraw from the school.

I understand that **no refunds for September 2020 will be given to withdrawals received later than June 30, 2020.**

I understand that **no refunds will be given for May 2021 and June 2021 after March 1, 2021.**

I understand that upon registration I am automatically a member of Tapestry Christian Early Learning Society, and I or other parent/guardian is required to attend the annual AGM.

**I agree and understand the registration policies and procedures.**

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

<b>OFFICE USE ONLY – PAYMENT HISTORY</b>									
<b>STUDENT START DATE: _____</b>									
<b>MONTHLY FEE: \$ _____</b>									
	<b>Amt Due</b>	<b>Date Processed</b>	<b>Cheque #</b>	<b>Staff Initial</b>		<b>Amt Due</b>	<b>Date Processed</b>	<b>Cheque #</b>	<b>Staff Initial</b>
<b>Reg Fee</b>	\$40	_____	_____	_____	<b>Dec</b>	\$ _____	_____	_____	_____
<b>Aug</b>	\$ _____	_____	_____	_____	<b>Jan</b>	\$ _____	_____	_____	_____
<b>Sept</b>	\$ _____	_____	_____	_____	<b>Feb</b>	\$ _____	_____	_____	_____
<b>Oct</b>	\$ _____	_____	_____	_____	<b>Mar</b>	\$ _____	_____	_____	_____
<b>Nov</b>	\$ _____	_____	_____	_____	<b>Apr</b>	\$ _____	_____	_____	_____
					<b>May</b>	\$ _____	_____	_____	_____



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

# 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 \_\_\_\_\_ Daytime phone \_\_\_\_\_  
Surname Given Name

Mother's Name \_\_\_\_\_ Daytime phone \_\_\_\_\_  
Surname Given Name

Guardian's Name \_\_\_\_\_ Daytime phone \_\_\_\_\_  
Surname Given Name

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								

**THIS IS AN IMPORTANT NOTICE.  
PLEASE HAVE SOMEONE TRANSLATE IT.**

<b>AMHARIC</b> <i>(Ethiopia)</i>	ይህ ጠቅላላ ግንኙነት ትኩረት ያስፈልጋል። እባክዎን ሌላ ሰው ያስተርጉሙልዎት።
<b>BURMESE</b>	ဤစာသည်အရေးကြီးသောသတိပေးအကြောင်းကြားစာဖြစ်ပါသည်။ ကျေးဇူးပြု၍တစ်ယောက် ယောက်ကိုတာသာပြန်ဆိုပါ။
<b>CHINESE</b>	這是一份重要通告，請找人為您翻譯。
<b>CROATIAN</b>	OVO JE VAŽNO OBAVJEŠTENJE. ZAMOLITE NEKOGA DA VAM GA PREVEDE.
<b>FRENCH</b>	CÉCI EST UN AVIS IMPORTANT. PRIERE DE LE FAIRE TRADUIRE.
<b>HINDI</b>	यह एक बहुत जरूरी सूचना है। कृपया किसी से इसका अनुवाद करवा लें।
<b>ITALIAN</b>	QUESTO È UN AVVISO IMPORTANTE, SIETE PREGATI DI FARVELO TRADURRE DA QUALCUNO.
<b>KHMER</b> <i>(Cambodia)</i>	នេះគឺជាសេចក្តីជូនដំណឹងសំខាន់មួយ សូមអ្នកដទៃប្រកបរបរជំនាញជួយ ឬ
<b>KOREAN</b>	중요한 안내사항입니다. 번역을 할 수 있는 분에게 도움을 청하시기 바랍니다.
<b>PERSIAN</b> <i>(Iran)</i>	این یک اطلاعیه مهم است. لطفا از کسی بخواهید آن را برای شما ترجمه کند.
<b>POLISH</b>	TO JEST WAŻNE ZAWIADOMIENIE. POPROŚ KOGOŚ ABY JE PRZETŁUMACZYŁ.
<b>PUNJABI</b>	ਇਹ ਇਕ ਜ਼ਰੂਰੀ ਸੂਚਨਾ ਹੈ। ਕਿਰਪਾ ਕਰਕੇ ਕਿਸੇ ਕੋਲੋਂ ਇਸ ਦਾ ਉਲੱਥਾ ਕਰਵਾ ਲਏ।
<b>SERBIAN</b>	OVO JE VAŽNO OBAVEŠTENJE. ZAMOLITE NEKOGA DA VAM GA PREVEDE.
<b>SOMALI</b>	KANI WAA OGEYSIIS MUHIIM AH. FADLAN QOF HA KUJ TURJUMO.
<b>SPANISH</b>	ÉSTE ES UN AVISO IMPORTANTE. POR FAVOR, BUSQUE A ALGUIEN QUE SE LO TRADUZCA.
<b>TAGALOG</b> <i>(Philippines)</i>	ITO AY ISANG MAHALAGANG PAUNAWA. MANGYARING IPASALIN ITO PARA MAUNAWAAN.
<b>VIETNAMESE</b>	ĐÂY LÀ THÔNG BÁO QUAN TRỌNG. HÃY NHỎ NGƯỜI DỊCH GIÚP.

Personal information on this form is collected, used and disclosed by VCH in accordance with the Freedom of Information and Protection of Privacy Act. Statistical information may be provided to the Ministry of Health Services for healthcare planning, program evaluation and quality improvement purposes. If you have any questions about the collection and use of this information, contact your local public health nurse or VCH’s Information Privacy Office at 604.875.5568 or email us at [privacy@vch.ca](mailto:privacy@vch.ca)

For vaccination schedules and more information call your local public health nurse or go to [www.immunizebc.ca](http://www.immunizebc.ca)



# 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

**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 \_\_\_\_\_

**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: \_\_\_\_\_

## 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.

# 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
<b>Staffing Requirements</b> Reg. 19 (3), 34 (1)			
<b>Adaptations/ Modifications to the Environment</b> Reg. 13 (4), 58 (f)			
<b>Adaptations/ Modifications to Program (activities/ routines)</b> Reg. 58 (ii) 3(c) 44 (2)			
<b>Dietary Requirements</b> Reg. 58 (3)(a) 48(1)(2) 57(h)			
<b>Medication</b> Reg. 58 (3)(e), 57 (2)(e)(f)(b) 53 (1)(2)(3)(4)			
<b>Health &amp; Safety Requirements/ First Aid</b> Reg. 58(0) 23(1)			
<b>Behavioural Guidance</b> 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 \_\_\_\_\_ Supervisor/Child Care Staff \_\_\_\_\_ Date \_\_\_\_\_

## 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

## Tapestry Christian Early Learning

### Registration Questionnaire

Dear Parents,

To help your child begin their year at Tapestry Christian Early Learning, it is helpful for the staff to know a little more about each child. We kindly ask that you answer the following questions.

CHILD'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

1. What are your child's interests?
2. Has your child attended any other group program independently?  
(ie: Sunday school, play group etc.)
3. What are your child's dislikes?
4. When your child gets upset, what does that look like?
5. What are positive ways you help your child when he/she is upset/angry/sad?
6. Has your child been observed or seen by any health care professionals?  
(i.e.: speech therapist, infant development professional, etc.)
7. Are there any concerns you have regarding your child that you would like the staff to be aware of?