



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

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March 2, 2020

Dear Parents/Guardians,

Thank you for choosing Tapestry Christian Early Learning! Enclosed, you will find the Registration Package for the 2020 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 Gyssel Romano, Program Director.

Sincerely,

Gyssel Romano

Program Director

Tapestry Christian Early Learning



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

**TAPESTRY CHRISTIAN EARLY LEARNING  
2020 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:             2015             2016             2017

Please indicate your camp preference below:

<b>Program</b>	<b>Dates &amp; Time</b>	<b>Cost</b>
Week 1 (Science)	<input type="checkbox"/> August 4 <sup>th</sup> – 7 <sup>th</sup> (9:00am – 12:30pm)	\$80
Week 2 (Art)	<input type="checkbox"/> August 10 <sup>th</sup> – 14 <sup>th</sup> (9:00am – 12:30pm)	\$100
Week 3 (Music & Movement)	<input type="checkbox"/> August 17 <sup>th</sup> – 21 <sup>st</sup> (9:00am – 12:30pm)	\$100
Week 4 (Outdoor Adventure)	<input type="checkbox"/> August 24 <sup>th</sup> – 28 <sup>st</sup> (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 Summer Camp Parent Handbook that can be found on TCEL's website ([www.tapestryearlylearning.com](http://www.tapestryearlylearning.com)) under admissions

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

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



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.**

- AMHARIC**    ይህ ጠቃሚ ማሳሰቢያ ነው። እባክዎን ሌላ ሰው ያስተርጉሙልዎት።  
*(Ethiopia)*
- BURMESE**    ဤစာသည်အရေးကြီးသောသတိပေးအကြောင်းကြားစာဖြစ်ပါသည်။ ကျေးဇူးပြု၍တစ်ယောက်  
ယောက်ကိုဘာသာပြန်နိုင်ပါ။
- CHINESE**    這是一份重要通告，請找人為您翻譯。
- CROATIAN**    OVO JE VAŽNO OBAVJEŠTENJE. ZAMOLITE NEKOGA DA VAM GA PREVEDE.
- FRENCH**    CECI EST UN AVIS IMPORTANT. PRIERE DE LE FAIRE TRADUIRE.
- HINDI**    यह एक बहुत जरूरी सूचना है। कृपया किसी से इसका अनुवाद करा लें।
- ITALIAN**    QUESTO È UN AVVISO IMPORTANTE, SIETE PREGATI DI FARVELO TRADURRE DA  
QUALCUNO.
- KHMER**    នេះគឺជាសេចក្តីប្រកាសដ៏សំខាន់មួយ សូមអ្នកអង្គុកបកប្រែជូនអ្នក ឬ  
*(Cambodia)*
- KOREAN**    중요한 안내사항입니다. 번역을 할 수 있는 분에게 도움을 청하시기 바랍니다.
- PERSIAN**    این یک اطلاعیه مهم است. لطفا از کسی بخواهید آن را برای شما ترجمه کند.  
*(Iran)*
- POLISH**    TO JEST WAŻNE ZAWIADOMIENIE. POPROŚ KOGOŚ ABY JE PRZETŁUMACZYŁ.
- PUNJABI**    ਇਹ ਇਕ ਜ਼ਰੂਰੀ ਸੂਚਨਾ ਹੈ। ਕਿਰਪਾ ਕਰਕੇ ਕਿਸੇ ਕੋਲੋਂ ਇਸ ਦਾ ਉਲਥਾ ਕਰਵਾ ਲਵੋ।
- SERBIAN**    OVO JE VAŽNO OBAVEŠTENJE. ZAMOLITE NEKOGA DA VAM GA PREVEDE.
- SOMALI**    KANI WAA OGEYSIIS MUHIIM AH. FADLAN QOF HA KUU TURJUMO.
- SPANISH**    ÉSTE ES UN AVISO IMPORTANTE. POR FAVOR, BUSQUE A ALGUIEN QUE SE LO  
TRADUZCA.
- TAGALOG**    ITO AY ISANG MAHALAGANG PAUNAWA. MANGYARING IPASALIN ITO PARA  
*(Philippines)* MAUNAWAAN.
- VIETNAMESE**    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: \_\_\_\_\_

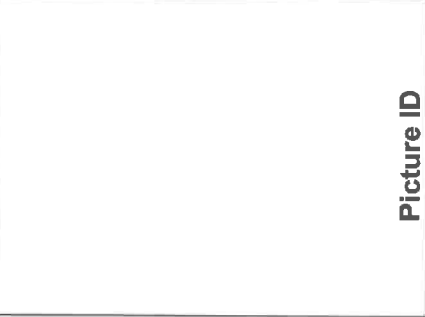
Parent/Guardian: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Phone (work): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Phone (work): \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Office Phone: \_\_\_\_\_



**Picture ID**

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



## 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
- short of breath
- coughing
- wheezing
- difficulty talking
- in-drawing/tracheal tug
- fast/shallow breathing
- other (list below): \_\_\_\_\_
- pale
- hunched over

## 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	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(e) 44 (2)			
<b>Dietary Requirements</b> Reg. 58 (3)(a) 48(1)(2) 57(h)			
<b>Medication</b> Reg. 58 (3)(a), 57 (2)(e)(f)(h) 53 (1)(2)(3)(4)			
<b>Health &amp; Safety Requirements/ First Aid</b> Reg. 58(f) 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

Manager

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?