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

February 1, 2021

Dear Parents/Guardians,

Thank you for choosing Tapestry Christian Early Learning! Enclosed, you will find the Registration Package for the 2021/2022 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, 2021-May 1, 2022)

☐ 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

___

TAPESTRY CHRISTIAN EARLY LEARNING
2021/2022 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: ☐ 2017 ☐ 2018 ☐ 2019

Please indicate your class preference below:

Program	Days	Time
Full Program	☐ Monday /Tuesday/Wednesday/Thursday/Friday	9:00am - 3:30pm
Morning	☐ Monday /Wednesday/Friday ☐ Tues/Thursday	9:00am – 12:30pm
Full Day	☐ Monday /Wednesday/Friday ☐ Tuesday/Thursday	9:00am – 3:30pm

Please indicate the corresponding payment schedule as shown below:

Program	Cost
☐ Full Program: M-F (9:00am to 3:30pm)	$850.00 per month
Morning program: ☐ M/W/F AM only (9:00am-12:30 pm) ☐ T/TH AM only (9:00am-12:30pm)	$330.00 per month $215.00 per month
Full-day program: ☐ M/W/F full day (9:00am-3:30pm) ☐ T/TH full day (9:00am-3:30pm)	$555.00 per month $400.00 per month
Drop In Fees (based on availability): Morning only (9:00am – 12:30pm) Afternoon only (12:30pm – 3:30pm) **Note: you must be in session in the morning to add this drop-in option* Full Day (9:00am – 3:30pm)	$30.00 $25.00 $50.00

Where did you hear about us?

____

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 2021 to May 2022. **Post-dated cheques are required.**

☐ I am aware that I must give **30 days written notice** before the first day of the calendar month to withdraw from the school.

☐ I understand that **no refunds for September 2021 will be given to withdrawals received later than July 30, 2021**.

☐ I understand that **no refunds will be given for June 2022 after April 30, 2022.**

☐ 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**______________

OFFICE USE ONLY – PAYMENT HISTORY

STUDENT START DATE: __________

MONTHLY FEE: $ ______________

	Amt Due	Date Processed	Cheque #	Staff Initial
Reg Fee	$50			
Aug	$			
Sept	$			
Oct	$			
Nov	$			

	Amt Due	Date Processed	Cheque #	Staff Initial
Dec	$			
Jan	$			
Feb	$			
Mar	$			
Apr	$			
May	$			

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

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								

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

AMHARIC *(Ethiopia)*	ይህ ጠቃሚ ማስታወቂያ ነው። እባክዎን ሌላ ሰው ያስተርጉምልዎት።
BURMESE	ဤစာသည်အရေးကြီးသောသတိပေးအကြောင်းကြားစာဖြစ်ပါသည်။ ကျေးဇူးပြု၍တစ်ယောက်ယောက်ကိုဘာသာပြန်ခိုင်းပါ။
CHINESE	這是一份重要通告，請找人爲您翻譯。
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 ज़रुरी सूचना है। कृपया किसी से इसका अनुवाद करा लें।
ITALIAN	QUESTO È UN AVVISO IMPORTANTE. SIETE PREGATI DI FARVELO TRADURRE DA QUALCUNO.
KHMER *(Cambodia)*	នេះគឺជាសេចក្តីប្រកាសដ៏សំខាន់មួយ សូមអ្នករកអ្នកបកប្រែជូនអ្នក ។
KOREAN	중요한 안내사항입니다. 번역을 할 수 있는 분에게 도움을 청하시기 바랍니다.
PERSIAN *(Iran)*	این یک اطلاعیهٔ مهم است. لطفا از کسی بخواهید آن را برای شما ترجمه کند.
POLISH	TO JEST WAŻNE ZAWIADOMIENIE. POPROŚ KOGOŚ ABY JE PRZETŁUMACZYŁ.
PUNJABI	ਇਹ ਇਕ ਜ਼ਰੂਰੀ ਸੂਚਨਾ ਹੈ। ਕਿਰਪਾ ਕਰਕੇ ਕਿਸੇ ਕੋਲੋਂ ਇਸ ਦਾ ਉਲੱਥਾ 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 *(Philippines)*	ITO AY ISANG MAHALAGANG PAUNAWA. MANGYARING IPASALIN ITO PARA MAUNAWAAN.
VIETNAMESE	ĐÂY LÀ THÔNG BÁO QUAN TRỌNG. HÃY NHỜ 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

For vaccination schedules and more information
call your local public health nurse or go to www.immunizebc.ca

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

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?

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

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.