



**TAPESTRY**  
CHRISTIAN EARLY LEARNING

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

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February 1, 2022

Dear Parents/Guardians,

Thank you for choosing Tapestry Christian Early Learning! Enclosed, you will find the Registration Package for the 2022/2023 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, 2022-May 1, 2023)
- 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 Gysssel Romano, Program Director.

Sincerely,

Gysssel Romano

Program Director

Tapestry Christian Early Learning



Please attach child's photo to this form

## Tapestry Christian Early Learning CHILD CARE EMERGENCY CONSENT FORM

CHILD'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ YEAR/MONTH/DAY  
ADDRESS: \_\_\_\_\_  
SURNAME, FIRST NAME(S)  
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 \_\_\_\_\_



Start Date: \_\_\_\_\_

**TAPESTRY CHRISTIAN EARLY LEARNING  
2022/2023 REGISTRATION FORM**

**Personal Information**

Child's Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Surname \_\_\_\_\_ DOB: 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:  2018  2019  2020

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)	\$875.00 per month
<b>Morning program:</b>	
<input type="checkbox"/> M/W/F AM only (9:00am-12:30 pm)	\$340.00 per month
<input type="checkbox"/> T/TH AM only (9:00am-12:30pm)	\$220.00 per month
<b>Full-day program:</b>	
<input type="checkbox"/> M/W/F full day (9:00am-3:30pm)	\$570.00 per month
<input type="checkbox"/> T/TH full day (9:00am-3:30pm)	\$410.00 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 2022 to May 2023. **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 2022 will be given to withdrawals received later than July 30, 2022.**
- I understand that **no refunds will be given for June 2023 after April 30, 2023.**

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	Amt Due	Date Processed
Reg Fee \$50	\$ _____	_____	_____	_____	\$ _____	_____
Aug	\$ _____	_____	_____	_____	\$ _____	_____
Sept	\$ _____	_____	_____	_____	\$ _____	_____
Oct	\$ _____	_____	_____	_____	\$ _____	_____
Nov	\$ _____	_____	_____	_____	\$ _____	_____
					\$ _____	_____
					\$ _____	_____
					\$ _____	_____
					\$ _____	_____
					\$ _____	_____
					\$ _____	_____

## 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**

Child's name \_\_\_\_\_ Surname \_\_\_\_\_ Given Name \_\_\_\_\_ Childcare facility \_\_\_\_\_ 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 \_\_\_\_\_ Surname \_\_\_\_\_ Given 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
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						

## 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



## Richmond Christian School Playground Walks

Hi TCEL families,

For the children who will be staying for the afternoon and do not nap we occasionally go on walks to the RCS to have a fun at their playground. Please indicate whether you give permission for your child to join us.

I give permission for Tapestry Christian Early Learning to take my child

\_\_\_\_\_ on walks to RCS Playground. Richmond Christian School

Playground is located on 5240 Woodwards Rd, Richmond, BC.

**Please check your choice below.**

- I give permission for my child to go on walks to RCS Playground.
- I do not give permission for my child to go on walks to RCS Playground.

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?

## 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 \_\_\_\_\_

**CHILD'S EMERGENCY TREATMENT:**

Medication is stored:

Medication expiry date: \_\_\_\_\_

Field Trip Plans: \_\_\_\_\_

**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 ASTHMA TRIGGERS ARE:**

change in temperature

change in animals (list): \_\_\_\_\_

change in foods (list): \_\_\_\_\_

change in strong smells (list): \_\_\_\_\_

Other: \_\_\_\_\_

colds, dust, emotion (e.g. upset)

mould

physical activity

pollen

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

**Asthma Emergency Action Plan for** \_\_\_\_\_ **year**

Child's Name: \_\_\_\_\_

Centre Name: \_\_\_\_\_

Age: \_\_\_\_\_

Centre Address: \_\_\_\_\_

- **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: \_\_\_\_\_  
 Program: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 Attendance (days/times in program): \_\_\_\_\_  
 Age \_\_\_\_\_ years \_\_\_\_\_ months  
 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):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Supervisor/Child Care Staff

Date

Manager

Date

Parent/Guardian

Date

Parent/Guardian

Date

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