TAPESTRY
CHRISTIAN EARLY LEARNING

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(604)277-1079
Info@tapestryearlylearning.com

February 1, 2023

Dear Parents/Guardians,

Thank you for choosing Tapestry Christian Early Learning! Enclosed, you will find the Registration Package for the 2023/2024 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, 2023-May 1, 2024)

☐ 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

Start Date: _____

TAPESTRY CHRISTIAN EARLY LEARNING
2023/2024 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: ☐ 2019 ☐ 2020 ☐ 2021

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 per month**	**Reduced rate***	***under 3yrs**
☐ Full Program: M-F (9:00am to 3:30pm)	$900.00	$355.00	$200.00
Morning program: ☐ M/W/F AM only (9:00am-12:30 pm) ☐ T/TH AM only (9:00am-12:30pm)	 $350.00 $227.00	 **$186.50** **$118.00**	 **$140.00** **$87.00**
Full-day program: ☐ M/W/F full day (9:00am-3:30pm) ☐ T/TH full day (9:00am-3:30pm)	 $587.00 $422.00	 $260.00 $204.00	 $167.00 $142.00
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)	**Daily fee** $30.00 $25.00 $50.00	***Note: Our reduce rate for 3-5 year olds and under 3 is depending on our grant approval.**	

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 2023 to May 2024. **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 2023 will be given to withdrawals received later than July 30, 2023.**

☐ I understand that **no refunds will be given for June 2024 after April 30, 2024.**

☐ 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								

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?

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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

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

March 2018

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.