Little World Educational Society
MCE Childcare Program
10721 - 86 Avenue, Edmonton, AB T6E2M8
Ph: (780) 439 – 8738 **e-mail: mcechildcare@gmail.com**

REGISTRATION / DEPOSIT FEE

Please send all deposits and completed/signed registration forms to: 10721 - 86 Avenue, Edmonton, AB T6E2M8

Contact: Benazir Ahmed, Off: (780) 439-8738

I_____understand and acknowledge that I must pay a

$ 200.00 deposit plus a **$ 50.00 registration fee** payable to:

MCE Childcare

I further understand that registration fee is **non-refundable** and the deposit will be adjust in the last month fee.

Print Name:

_____

Signature:

_____

Date:

_____

(This form must becompleted, signed, dated and returned with registration.

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Child's Name: _____

Date of Registration: _____ Starting date: _____

Child's Age: _____Male ☐ Female ☐ Child's Date of Birth: _____

Legal Guardian Name: _____Email Address: _____

Home Address: _____

Legal Guardian Home Phone: _____Cell#: _____

Legal Guardian Place of Work: _____Phone:_____

Is Legal Guardian allowed to pick up child Yes ☐ No ☐

Mother's Name: _____Email Address:_____

Mother's Home Address: _____

Mother's Home Phone: _____Cell#: _____

Mother's Place of Work: _____Phone:_____

Is mother allowed to pick up child? Yes ☐ No ☐

Father's Name: _____Email Address:_____

Father's Home Address: _____

Father's Home Phone: _____Cell#: _____

Father's Place of Work: _____Phone:_____

Is father allowed to pick up child? Yes ☐ No ☐

Child's Home Phone: _____

Child's Home Address: _____

Edmonton, Alberta, Postal Code:_____

Parent to be contacted in Emergency:_____

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Emergency Contact Person#1:_____Relationship to Child:_____

Emergency Contact Address:_____

Emergency Person Place of Work:_____

Work Phone:_____ Home Phone:_____ Cell#:_____

Emergency Contact Person#2:_____Relationship to Child:_____

Emergency Contact Address:_____

Emergency Person Place of Work:_____

Work Phone:_____ Home Phone:_____Cell#:_____

Family Physician:_____ Phone: _____

Child's Alberta Healthcare Number:_____

Is the child on daily medications? Yes ☐ No ☐

If yes, what name?_____

What dosage?_____ How many times a day?_____

Any allergies or medical problems? Yes☐ No☐

If yes, please describe:_____

Is child's immunization up to date? Yes☐ No☐

Any other information the staff should be aware of? Yes☐ No☐

If yes, please specify:_____

Is anyone **NOT** allowed to pick up the child?: Yes ☐ No ☐

If yes, name of person(s):_____ Relationship to Child:_____

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- Children **WILL NOT** be released to anyone who is not authorized in writing by the parent/ legal guardian.
- **NO TELEPHONE CALLS** are acceptable to change authority for pick-up authorization **(MUST BE IN WRITING).**
- All persons picking up the child **MUST** provide picture identification.
- MCE Child care reserves the right to refuse **ANY ONE** picking up a child who does not appear to be in a responsible condition.

BESIDES THE PARENTS, LIST BELOW OTHER PERSONS THAT YOU AUTHORIZE TO PICKUP YOUR CHILD:

Name: _____

Phone:_____Cell#_____ e-mail:_____

Address:_____

Relationship to Child:_____

Name: _____

Phone:_____Cell#_____ e-mail:_____

Address:_____

Relationship to Child:_____

Has child been in childcare before? Yes☐ No☐

If yes, name of center: _____

Child will arrive at center at what time? _____

Child will be picked up at what time?_____

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- Children must be dropped off at 7:00am & picked up no later than 6:00pm.
- A **$20.00** "LATE FEE" will be charged per 15 minutes of being late for pick-up.

INITIAL: _____

I understand that the monthly fee for my child is due and payable on the day the child starts, and that monthly fees are due on the first day of each month (if the first is a holiday, then the fees are due on the next business day that the center is open). If monthly fees are not received on the 1st of the month, a late fee will be due in the amount of $40.00 unless previous arrangements have been made. Parents are encouraged to pay using post-dated cheque.

INITIAL: _____

I understand that **I AM REQUIRED TO GIVE MCE CHILDCARE ONE(1) FULL MONTH "WRITTEN" NOTICE TO THE DIRECTOR OR APPOINTED CONTACT PERSON PRIOR TO REMOVING MY CHILD**. If I fail to provide that "Written" notice, I will be required to pay one additional month's fees.

INITIAL _____

The parent who want to hold place for their child in daycare they have to pay full fee for 1st month and 75 percent of fee for following months.

There will be $35 charged for any of the duplicate receipt for the purpose of the income tax or for the custody letter or for any other reason. The duplicate receipt will be provided only on parent/ guardian/ request.

INITIAL _____

HEALTH QUESTIONNAIRE AND IMMUNIZATION RECORD FOR CHILDCARE

Dear parent or guardian:
The Board of Health provides preventative programs for Edmonton residents, which are carried out by public health nurses in regional health centers. In order to better understand the health of your child in childcare, would you please complete these questions about his/her health:

IN THE LAST YEAR, HAS THE CHILD HAD ANY DIFFICULTY WITH THE FOLLOWING?:

EARACHE	YES ☐	NO ☐	If YES, Please specify: _____
SPEECH	YES ☐	NO ☐	If YES, Please specify: _____
HEARING	YES ☐	NO ☐	If YES, Please specify: _____
VISION	YES ☐	NO ☐	If YES, Please specify: _____
FOOD/EATING	YES ☐	NO ☐	If YES, Please specify: _____
SLEEPING	YES ☐	NO ☐	If YES, Please specify: _____
BOWELS	YES ☐	NO ☐	If YES, Please specify: _____
WETTING(day)	YES ☐	NO ☐	If YES, Please specify: _____
WETTING(night)	YES ☐	NO ☐	If YES, Please specify: _____
FEVER	YES ☐	NO ☐	If YES, Please specify: _____
MAKINGFRIENDS	YES ☐	NO ☐	If YES, Please specify:

Is your child developing as you think he/she should for this age?(eg. Talks, sits up, toilet trained) YES ☐ NO ☐ If YES, Please explain: _____

Has this child had any medical or emotional conditions requiring/ receiving treatment? YES ☐ NO ☐ If YES, Please explain: _____

Has the child had any of the following conditions or diseases?:

Allergies	YES ☐	NO ☐	Date:_____	Jaundice	YES ☐	NO ☐	Date:_____
Describe allergy:	_____			Heart Condition	YES ☐	NO ☐	Date:_____
Rubella	YES ☐	NO ■	Date:_____	Convulsions	YES ☐	NO ☐	Date:_____
Measles	YES ■	NO ☐	Date:_____	Epilepsy	YES ☐	NO ☐	Date:_____
Chicken Pox	YES ☐	NO ☐	Date:_____	Head injury	YES ☐	NO ☐	Date:_____
Whooping Cough	YES ☐	NO ☐	Date:_____	Poisoning	YES ☐	NO ☐	Date:_____
Mumps	YES ☐	NO ☐	Date:_____	Surgery	YES ☐	NO ☐	Date:_____
Diabetes	YES ☐	NO ☐	Date:_____	Tuberculosis	YES ☐	NO ☐	Date:_____

IMMUNIZATION: Immunization is an important way of controlling the spread of some childhood diseases. This is the recommended schedule for your child's immunization:

PRIMARY	1ST VISIT	2 MONTHS OF AGE	DPT&POLIO	DPT	DIPTHERIA
	2ND VISIT	2 MONTHS AFTER 1ST VISIT	DPT&POLIO		PERTUSSIS
	3RD VISIT	2 MONTHS AFTER 2ND VISIT	DPT		TETANUS
	4TH VISIT	12 MONTHS OF AGE	MMR	MMR	MEASLES
BOOSTER	5TH VISIT	12 MONTHS AFTER 3RD VISIT 18 MONTHS OF AGE 4–6YEARSOFAGE	DPT&POLIO HIB DPT&POLIO	HIB	MUMPS RUBELLA HAEMOPHILUS INFLUENZAEB

Please enter dates of immunizations that your child has received to date in appropriate space below.

DIPTHERIA	WHOOPINGCOUGH(PERTUSSIS)	TETANUS	POLIO	MMR	HIB

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I,_____hereby give permission to **MCE Childcare** to photograph_____ (name of child) in his/her daily activities and special events and understand that they may be displayed on the picture board. No pictures will be used for publication or telecast.

I hereby grant permission for my child to leave the centre premises under the supervision of the staff members of **MCE Childcare** for outdoor walks, field trips (i.e. sledding, or going to play in the nearby play ground), and other such related activities.

I also grant permission for the Owner, Administrator, Director, or Acting Incharge Staff to take what ever steps are necessary to obtain emergency medical treatment if warranted. I will also be responsible for any ambulance expenses. These steps may include, but are not limited to : **a.** Attempt to contact a parent or guardian **b.** Attempt to contact the child's physician **c.** Have the child transported to an emergency facility/hospital in the company of a staff member.

I grant permission for and give consent to medical or surgical treatment by a licensed physician and /or hospital, and further consent to the administration of any necessary anesthetics, medical treatments including tests, transfusions, injections, or drugs, and the performing of what ever operations may be deemed necessary or advisable in the event of an emergency.

I/We acknowledge that **MCE Childcare** endeavors to provide the finest care possible for all children enrolled in its program. Accordingly, I/We acknowledge **MCE Childcare** reserves the right to refuse enrollment or the continued enrollment of my child, should the management of **MCE Childcare** in its sole discretion, determine that my child poses a health, behavioral or management problem to its childcare, operation or staff.

I/We acknowledge that we have read the contents of the PARENT HAND BOOK and agree to be bound and abide by the rules and regulations set for the therein. However, I/we acknowledge that the PARENT HANDBOOK is setup to regulate the day-to-day activities and long range plans of the centre, as well as to inform parents of the goals and working of the Child Care Centre, and as such, the contents there of may be subject to change by **MCE Childcare** in its sole discretion. I/We here by agree to abide to any new rules or regulations established by **MCE Childcare** and communicated to me/us.

Should legal action be necessary, I understand that all legal fees will be at my cost.

Parents Signature:_____

I understand all of the details of the "Registration Form" including the "Late Fee" structure and the "Notice when leaving" requirements.

SIGNED_____

PRINT NAME : _____

DATE:_____

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Touch Policies of Children

MCE Child Care consider about touch policy to ensure children's safety and understanding of parent between the child and staff. Touch policy consider both appropriate and inappropriate touch of the staff during their interaction with the children in center.
For the acknowledgement of the parent that the MCE Child Care staff consider physical contact as an important part of child development and for child guidance. There are some touch examples which are followed below.

Appropriate Touch:

- Diapers change and putting rashes cream with the cotton swab on the private area of the children.
- Assisting zipper and button around the private area.
- Hugs lap sitting for the younger children, back rub, touch for the health and wellness and reassuring touches on shoulders.
- Respecting children personal privacy and personal space of children.
- Responses affecting the safety and well-being of the child for example hold hand of a child while crossing the street, holding firmly and gently during child's temper tantrum.

Inappropriate Touch:

- Forced kisses, corporal punishment, slapping, striking, pinching, tickling for prolong period, fondling or molestation.
- Any attempt to change child's behaviour with adult physical force, often applied in anger.
- violation of laws against sexual contact between adults and children.
- Satisfaction of adult needs at the expense of the child.
- coercion or other forms of exploitation of the child's lack of knowledge.

Inappropriate touching will be grounds for immediate investigation and termination of the staff from the center.

Parent Name:_____
Parent Signature:_____
Date:_____

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ABSENT PARENT PERMIT FOR EMERGENCY MEDICAL/SURGICAL CARE

In the event that my child (listed below) may require medical and/or surgical care when I am unable to be reached, I hereby authorize evaluation, treatment, and anesthetics, as deemed necessary by the_____ Hospital, and attending physician for the following child:

Child's Name _____ DOB: _____ Age: _____

Allergies: _____

Present Medication: _____

Medical History: _____

Surgical History: _____

Other Pertinent Information: _____

Family Physician: _____ Phone Number: _____

Family Medical Insurance Co: _____ Policy #: _____

Person(s) able to provide authorizing signature when parent(s) are unable to be reached:

Name: _____

Address: _____

Home Phone #: _____ Work Phone #:_____Cell #_____

Relationship to the child: _____

Parent's Signature: _____

Address: _____

Home Phone #: _____Work Phone #:_____

Mom's Cell #: _____ Dad's Cell #: _____

Email Mom: _____Email Dad: _____

AUTHORIZATION IS TO BE LEFT WITH THE RESPONSIBLE ADULT AND PRESENTED TO THE HOSPITAL STAFF AT THE TIME EMERGENCY MEDICAL AND/OR SURGICAL CARE IS REQUIRED.

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PERMISSION TO ADMINISTER

Child's Name: _____

I hereby give/withhold my permission for _____, my child's childcare provider, to administer the following non-prescription items:

YES	NO	PRODUCT	INSTRUCTIONS
_____	_____	Diapering Products	_____
_____	_____	Insect Repellent	_____
_____	_____	Sunscreen	_____
_____	_____	Tylenol	_____
_____	_____	Pain Relievers	_____

We have also discussed the following non-prescription items so we have a clear mutual understanding about if they are to be used, which will provide them, any brand preference and any allergic reactions my child has had to these products:

Cough Syrup and Cold Remedies: _____

Products for relieving teething pain: _____

Ointments or creams for rashes, itches or first aid use: _____

Baby Powder, Baby Oil and or Baby Lotion: _____

Liquid Soaps, Bar Soaps and/or Shampoos: _____

Adhesive Tape, Band-Aid's: _____

Other: _____

Parent's Signature: _____ Date: _____