Toddler Enrollment Form

Child's Full Legal Name: _____

Date of Birth_____ Age _____

Address_____ Postal Code _____

Parent Information

Parent/Guardian 1

Parent Name: _____

Primary Phone Number: _____

Alternate Phone Number: _____

Email Address: _____

Home Address: _____

□ Same as Child

Parent/Guardian 2

Parent Name: _____

Primary Phone Number: _____

Alternate Phone Number: _____

Email Address: _____

Home Address: _____

□ Same as Child

Office Use

Enrolment Start Day: Enrolment End Day:

Other:

Toddler Programs

Half Day Program (9:00 am – 12:00 pm) *Please circle days attending*

Monday Tuesday Wednesday Thursday Friday

Extended Day Program (9:00 am – 2:25 pm) *Please circle days attending*

Monday Tuesday Wednesday Thursday Friday

Full Day Program (9:00 am – 4:00 pm) *Please circle days attending*

Monday Tuesday Wednesday Thursday Friday

Extended Care

□ Extended Morning Drop off □ 7:45 am – 8:30 pm

□ Extended Pick Up □ 4:00 pm – 5:00 pm □ 4:00 pm – 6:00 pm

Diaper/Toileting Requirements

Is your child in Diapers? □ YES □ NO

If **no,** my child: □ Uses the washroom independently.

□ Requires Assistance □ Requires Full Support

Please prove details, if necessary:

Sleep Arrangements

Does your child nap each day and for how long? _____

Does your child have any special sleep arrangements? (E.g., comfort item, soother)?

□ YES □ NO

If yes, please provide relevant: _____

Your Child's Heath

If your child is anaphylactic? (*Please circle)* YES NO

Does your child need an Epi-Pen? (*Please circle)* YES NO

Are you concerned that your child may be prone to any type of allergies? Please describe.

Does your child have any medical condition of which we should be made aware?

Has your child had the following common childhood illness?

- ☐ Constipation
- ☐ Convulsions
- ☐ Diarrhea
- ☐ Fainting Spells
- ☐ Frequent Colds
- ☐ Frequent Ear Infections
- ☐ Skin Rash
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ heart disease
- ☐ Mumps
- ☐ Measles

Does your child have any speech, language, hearing or visual delays?

Are there any food restrictions?

What language (s) are spoken at home?

Is there any other information you would like to let us know about?

Emergency Contacts

In the event of an emergency, if parents cannot be reached, the following individual(s) may be contacted. Please list in order of preference.

Emergency Contact # 1

Contact Name: _____

Primary Phone Number: _____

Alternate Phone Number: _____

Relationship to Child: _____

Home Address: _____

□ Authorized to pick-up child

Emergency Contact # 2

Contact Name: _____

Primary Phone Number: _____

Alternate Phone Number: _____

Relationship to Child: _____

Home Address: _____

□ Authorized to pick-up child

Emergency Contact # 3

Contact Name: _____

Primary Phone Number: _____

Alternate Phone Number: _____

Relationship to Child: _____

Home Address: _____

□ Authorized to pick-up child

Play Loft Authorization for Child Pickup

We would like to remind all parents of Play Loft's policy regarding the safe pick-up of childrenother than the parent or legal guardian. As a measure of security, we require prior written notification from parents authorizing the person(s) to pick up your child (ren) from school, either on a regular or occasional basis.

To this effect, by signing this form, parents will inform Play Loft of the person(s) allowed topick-up their child (ren) for the current school year only.

In the event of an unforeseen emergency, whereby a different person other than those listed on the Authorization Form will be picking up your child, we ask that a parent telephone Play Loft as soon as possible to apprise us of this situation. Play Loft's policy is such that we will not allow someone to leave with a child without prior notification from the parents. The safety of your child is of utmost importance, and we know that you, as parents, willunderstand the reasons for this policy.

Full Legal Name	Relationship to Child	Primary Phone Number

Parent Signature: _____ **Date:** _____

Custody Arrangements (If applicable)

Are there custody arrangements pertaining to legal right of access to your child? **YES** **NO**

If YES, please provide a copy of the appropriate legal documentation (e.g., court order)

Name(s) of custodial parent(s):

_____

Name(s) of individuals prohibited from accessing/picking up your child:

_____

Parent Signature: _____ **Date:** _____

Lunch Program & Diet Request Form

By signing this document, I_____am acknowledging that I have read and understood Play Loft's No Lunch Bag Policy and agree for my child to participate in the catered lunch program offered at Play Loft.

Dietary Practice

☐ HALAL	☐ LACTO-OVO
☐ KOSHER	☐ OVO
☐ NO RED MEAT	☐ VEGETARIAN
☐ CHICKEN	☐ VEGAN
☐ FISH	☐ OTHER:

Food Restrictions / Allergies

PROTIEN: ☐ LEGUMES ☐ EGG ☐ FISH ☐ MEAT ☐ OTHER:

MILK PROTIENS: ☐ ALL ☐ OTHER

VEGETABLES: ☐ RAW ☐ COOKED ☐ LIST THE VEGETABLE(S):

FRUITS: ☐ CITRUS ☐ LIST THE FRUIT(S):

GRAINS: ☐ WHEAT ☐ RICE ☐ OTHER GRAINS:

Food Intolerance

☐ LACTOSE ☐ GLUTEN ☐ MSG ☐ OTHER:

Symptoms & Exposure

What type of contact causes the reaction? *Please check one.*

☐ Airborne (smelling) ☐ Trace Cross Contact (touching) ☐ Actual ingestion (eating)

Please explain: (reaction or symptom):

Any Additional Information, please list below:

Parent Signature: _____ **Date: _____**

Authorization for Non-Prescription Medications

The following: **sunscreen, moisturizing skin lotion, lip balm, insect repellent, hand sanitizer and diaper** cream can have a single parent authorization (written approval) and can be administered without medication consent form as long as they are non-prescription. Play Loft staff require the product to be in its original packaging or we will not be able to apply to your child. Please note, Play Loft staff will not track and document the administration of the following items:

I give permission for Play Loft staff to administer the following products as per the packaging directions. *Please note all items must be in the original container for staff to administer.*

(a) Sunscreen

(b) Moisturizing skin lotion

(c) Lip balm

(d) Insect repellent

(e) Hand sanitizer

(f) Diaper cream

Important Note:

- The product must be hand given to a Play Loft staff, labeled with your child's initials, never to be left in the child's cubby and/or backpack
- All parents must provide written consent for Play Loft staff to administer non-prescribed medications; otherwise, we are unable to do so.
- Play Loft staff will only administer non-prescribed medications and creams in their original packaging
- The product must be provided by the parent/guardian

I hereby give permission for Play Loft staff to administer the above product to my child.

Parent Name: _____ Parent Signature: _____

Supervisor Signature: _____ Date: _____

Emergency Permission Card

Child's Name _____ **Birth Date** _____

Adress _____ **Phone** _____

Hair Color _____ **Eye Color** _____

Parent Guardian 1	Parent Guardian 2
Name _____	**Name** _____
Cell Phone _____	**Cell Phone** _____
Work Phone _____	**Work Phone** _____

Emergency Contact Name _____

Emergency Contact Phone _____

Child's Doctor _____ **Phone** _____

Health Card Number _____

Allergies _____ **Medication** _____

Medical Condition _____

In permitting my child to attend Play Loft programs; I, the undersigned, permit my child to participate in the full range of activities and authorize Play Loft, in the event of a accident, or illness affecting this above named child to authorize on my behalf all procedures, including transportation by ambulance, admission to the hospital and necessary treatment there in as he/she may deem essential for the care and well-being of the child. It is Play Loft's policy to notify a parent when a child is ill or in need of medical attention. When deemed necessary by staff, emergency medical help will be sought first, and parents contacted second. It is understood that Play Loft is not responsible for medical care or ambulance cost.

I hereby give permission to staff at Play Loft to make necessary transportation arrangements for my child who becomes ill or injured.

I, the undersigned, hereby certify that all the information provided is true and correct to the best of my knowledge and belief. In signing this application with an electronic signature, I acknowledge and agree that such electronic signature has the same legal effect as a written signature.

Parent Name: _____ **Parent Signature: _____**

Immunization Records

Under the Child Care and Early Years Act, Section 35 (1) of O. Reg. 137/2015 all children who attend a Child Care Centre must be vaccinated according to Ontario's Publicly Funded Immunization Schedule, as recommended by the local Medical Officer of Health. Annual flu vaccination is also strongly suggested.

Exemptions:

If an exemption is required, please complete either of the two forms stating the reason for exemption.

Name of Child Care Center: Play Loft

Child's Name: _____

Date of Birth: _____

Home Address: _____

Parent Guardian Name: _____

Telephone Number: _____

Doctor's Name: _____

Doctor's Telephone Number: _____

Please attach a photocopy of your child's immunization records to Play Loft upon registration of your child to the program.

Ontario

Ministry of Education

Statement of Conscience or Religious Belief for Child

Child Care and Early Years Act, 2014

Affidavit

I, _____,
(Last Name, First Name)

parent of the following named child:

Last Name	First Name	Date of Birth (yyyy/mm/dd)

Home Address

Unit Number	Street Number	Street Name

City/Town	Province	Postal Code

Child Care Centre / Home Child Care Agency

_____

make oath or solemnly affirm and say as follows:

1. Immunization conflicts with my sincerely held religious or conscious convictions.
2. I make this affidavit for the purposes of complying with the requirements of subsection 35(2) of Ontario Regulation 137/15 under the *Child Care and Early Years Act, 2014*, and for no other or improper purpose.

SWORN OR SOLEMNLY AFFIRMED before me

at _____
(Municipality/First Nation)

in _____
(Province)

on _____
(Date (yyyy/mm/dd))

_____
Parent of Named Child Signature

_____
Signature of Commissioner for Taking Affidavits

_____
Type or Print name if signature is illegible (Last Name, First Name)

Personal information on this form is provided to your child care provider as required under subsection 35(2) of Ontario Regulation 137/15 under the *Child Care and Early Years Act, 2014*. The information may be collected and used by the Ministry of Education in the course of confirming compliance with that subsection. The information may also be collected and used by the Medical Officer of Health pursuant to clause 72(6)(a) of Ontario Regulation 137/15 under the *Child Care and Early Years Act, 2014* in order to support the health and well-being of children. Questions about this collection should be directed to: Manager, Licensing and Compliance, Ministry of Education, 77 Wellesley Street West, Box 980, Toronto ON M7A 1N3, or by calling the Child Care Licensing Help Desk at 1-877-510-5333.

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Ontario Ministry of Education

Statement of Medical Exemption for Child

Child Care and Early Years Act, 2014

Notice of Collection of Personal Information

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Section 1 – Child Information

Last Name	First Name	Date of Birth (yyyy/mm/dd)

Home Address

Unit Number	Street Number	Street Name

City/Town	Province	Postal Code

Child Care Centre / Home Child Care Agency

Section 2 – Declaration of Regulated Health Professional

I, _____ , certify that,
(Name of Regulated Health Professional) (Last Name, First Name)

for medical reasons indicated below, the above named child should be exempted from the requirements of Ontario Regulation 137/15 under the *Child Care and Early Years Act, 2014*.
The specific reasons and length of exemptions are checked in the boxes below.
The time periods for temporary medical exemptions are indicated.

Disease	Immunity		Contraindication	Length of Exemption			
	Clinical diagnosis of prior disease	Laboratory confirmation of immunity or prior disease	Detrimental to health	Permanent	Temporary	From (yyyy/mm/dd)	To (yyyy/mm/dd)
Diphtheria			☐	☐	☐	/	
Tetanus			☐	☐	☐	/	
Pertussis			☐	☐	☐	/	
Poliomyelitis			☐	☐	☐	/	
Meningococcal Disease			☐	☐	☐	/	
Measles		☐	☐	☐	☐	/	
Mumps		☐	☐	☐	☐	/	
Rubella		☐	☐	☐	☐	/	
Haemophilus Influenza Type B (Hib)	☐	☐	☐	☐	☐	/	
Varicella	☐ *	☐	☐	☐	☐	/	

*Clinical diagnosis of prior varicella or herpes zoster disease is acceptable for varicella immunity.

Use this space to define evidence of immunity.

Use this space for explanations of contraindications detrimental to health.

Section 3 – Signature

Name of Regulated Health Professional (Last Name, First Name)	Registration or Licence Number

Business Address

Unit Number	Street Number	Street Name	PO Box

City/Town	Province	Postal Code

Signature of Regulated Health Professional	Date (yyyy/mm/dd)

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