COUCHICHING CHILD CARE CENTRE

Registration Form

Childs Information

Childs Name: _____ Birthday: _____

Address: _____ Town: _____

Province: _____ Postal Code: _____

Phone: _____

Nickname (if any) _____ Traditional Name: _____

Mother/Guardian Information

Name: _____ Home Telephone: _____

Cell: _____ Address: _____

Town: _____ Province: _____

Postal Code: _____ Occupation: _____

Business Address: _____ Work Telephone: _____

Fathers Information

Name: _____ Home Telephone: _____

Cell: _____ Address: _____

Town: _____ Province: _____

Postal Code: _____ Occupation: _____

Business Address: _____ Work Telephone: _____

Revised November 20, 2025

Medical History

Family Physician: _____ Phone: _____

Full Address: _____

Childs previous history of communicable diseases: _____

_____

_____

Does your child need regular medication for health problems? YES ( ) NO ( )

If Yes what and when is it given: _____

_____

Childs Allergies? YES ( ) NO ( ) If YES list allergies: _____

Special instructions in the event of an allergic reaction: _____

_____

Record of immunization (if child has not been immunized, a parent of the child must provide a written statement that immunization conflicts with the sincerely held convictions of the parent(s) religion or conscience or a legally qualified medical practitioner must give medical reasons in writing as to why the child should not be immunized) Please circle

Diphtheria Pertussis Tetanus Polio Rubella Mumps Measles

Please attach a copy of immunization record

Does your child have any mental or physical disabilities? YES ( ) NO ( )

If YES explain: _____

_____

Emergency Contact Information

Name of the person to be contacted if parent cannot be reached in case of emergency during hours of care. Be advised that no children under the age of 16 years of age will not be allowed to pick up your child.

Primary Contact Person

Name: _____ Home telephone _____

Address: _____ Work telephone _____

Cell: _____ Relationship to child: _____

Secondary:

Name: _____ Home telephone: _____

Address: _____ Work telephone: _____

Cell: _____ Relationship to the child: _____

Name: _____ Home telephone: _____

Address: _____ Work telephone: _____

Cell: _____ Relationship to the child: _____

Name: _____ Home telephone: _____

Address: _____ Work telephone: _____

Cell: _____ Relationship to the child: _____

Questionnaire:

What are your childs sleeping habits? _____

_____

What are your childs likes and dislikes with food? _____

_____

Is your child potty trained? YES ( ) NO ( ) _____

Is your child self -sufficient in the bathroom? YES ( ) NO ( ) _____

Special requirements for diet, rest or exercise? _____

_____

_____

Please comment on your childs developmental (eg. Habits, favorites, activities, fears etc.)

_____

_____

_____

Any previous Child Care Centre that your child has attended: _____

Any Problems: _____

Other Information: _____

_____

_____

Parents Signature: _____

Supervisors Signature: _____

Date: _____

****

Office Use Only

Date of Entry: _____

Date of Exit: _____

Reason for Completion: _____

Emergency Medical Attention

I _____ grant permission for the Child Care Centre staff to take whatever steps may be necessary to obtain emergency medical care for my child_____
In the event of injury or illness while he/she is in attendance at the above Child Care Centre.

I understand that these steps may include but are not limited to the following:

1. The child will receive immediate preliminary first aid treatment from a Child Care staff member.
2. Child Care staff will attempt to obtain the immediate service of the community health worker, physician, or health nurse or other medical practitioner.
3. Child Care Centre staff will attempt to contact the child's parent/guardian or any of the contact people, if they cannot be reached, arrangements will be made to transport the child for emergency treatment at the nearest hospital in the company of a Child Care staff member.

I realize that every precaution will be taken to ensure the health, safety and well- being of all children in care and I hereby release the above Child Care Centre and its staff members from liability regarding injury or illness involving my child while he/she is in attendance.

_____ _____

Signature of Parent/Guardian Date

Outing Permission

I give my permission for my child _____

To be taken on local outings or excursions by the Child Care Centre staff. Local outings may include walks, picnics or visits to places of interest in the community. I understand that I will be given prior notice and will have the opportunity to give consent in writing regarding any other major outings that are organized. I have read and fully understand the above.

_____ _____

Signature of Parent/Guardian Date

****

Photograph Permission

I give my permission for my child _____

to be photographed, videotaped or audio taped while at the Child Care Centre or on field trips. I understand that the result of the photographs, video or audio tapes may be used for publicity or promotion of the program. All videos, brochures and materials will be used to promote Quality Child Care that is developmentally and culturally appropriate. I have read and fully understand the above.

_____ _____

Signature of Parent/Guardian Date

Couchiching Child Care Centre

Emergency Information

Childs Name:

Mothers Name:

Home Phone: Work Phone:

Cell:

Fathers Name:

Home Phone: Work Phone:

Cell:

Name of Person(s) to contact if parent(s)/guardians cannot be reached:

1st: Home/Work/ Cell Numbers:

2nd: Home/Work/Cell Numbers

Physician Name:

Address:

Phone Number:

Medical/ Allergy Information

Couchiching Child Care Centre

Behavior Management Policy for Parents/Guardians/Visitors

In order to ensure the safety, security and respectful atmosphere for our children, staff and others in the Child Care Centre, the following is in effect:

There will be no verbal, physical or other use of any manner to be used in the presence of any child, staff member, or other persons in the Child Care Centre.

There will be no tolerance of any foul language, racial slurs, physical abuse or yelling at any persons in the presence of any child or staff at the Child Care Centre.

There will be absolutely no written posts regarding staff and/or children of the Couchiching Child Care Centre on any form of social media.

There will be **Zero Tolerance** for any non-compliance of Couchiching Child Care Philosophy

Any infractions of these guidelines will result in immediate corrective action. Depending on severity of actions and immediate permanent discharge from childcare may be involved.

All facts and remarks made during the incident will be kept on file.

The appropriate authorities will be given a statement regarding the incident.

1st Parent / Guardian Signature _____ Date_____

2nd Parent / Guardian Signature _____ Date_____

Couchiching Child Care Centre
Behaviour Management Policy for Parent(s)/Guardians

If any parent/guardian becomes verbally/physically abusive to Administration Staff, Student teachers, Volunteers or children of the Centre:

Procedure

First Incident: Staff documents incident and the parent(s)/guardian is provided with a written warning that must be signed by the parent, staff and Supervisor.

Second Incident: The Supervisor will consult the Chief and Council. The family will be notified in writing of termination of services.

If parent(s)/guardian fail to comply with the policies and procedures agreed upon enrollment:

Procedure:

First Incident: Meeting with the Supervisor to discuss issue.

Second Incident: Written warning signed by parent(s)/guardian Supervisor and Chief and Council.

Third Incident: The Chief and Council will be consulted by the Supervisor. The family will be notified in writing of termination of services.

1st Parent/Guardian Signature _____ Date _____

2nd Parent/Guardian Signature _____ Date _____

Couchiching Child Care Centre

Family Agreement Form: Parent Handbook Acknowledgement

Child's Name: _____

Parent(s)/Guardian(s): _____

Date: _____

Acknowledgement of Receipt

By signing below, I/we acknowledge that I/we have received and read the Couchiching Child Care Centre Parent Handbook. I/we understand that it contains important information about the program's policies, procedures, and expectations.

Agreement to Abide by Policies

I/we agree to adhere to the policies and guidelines outlined in the Parent handbook. I/we understand that failure to comply with these policies may result in termination of Child Care.

Communication of Concerns

I/we understand that if I/we have questions or concerns regarding the programs policies or practices, the appropriate course of action is to bring them to the attention of the program manager or designate manager.

Parent/Guardian Name: _____

Signature: _____ **Date:** _____

WAIVER OF EMPLOYMENT VERIFICATION

I give the Supervisor, Assistant Supervisor and or the Administrator of the Couchiching Child Care Centre permission to contact my place of employment and/or Educational Institute.

_____

Place of Employment / School & Name of Contact Person

Where they will verify that I am employed / attending the following days and hours:

Monday _____

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

I give this permission on the understanding that the information obtained will be kept for is only by the Couchiching Child Care Centre and handled in a professional matter.

_____ _____

Signature of Employee / Student Date

_____ _____

Signature of Witness Date

WAIVER OF EMPLOYMENT VERIFICATION

I give the Supervisor, Assistant Supervisor and or the Administrator of the Couchiching Child Care Centre permission to contact my place of employment and/or Educational Institute.

_____

Place of Employment / School & Name of Contact Person

Where they will verify that I am employed / attending the following days and hours:

Monday _____

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

I give this permission on the understanding that the information obtained will be kept for is only by the Couchiching Child Care Centre and handled in a professional matter.

_____ _____

Signature of Employee / Student Date

_____ _____

Signature of Witness Date

I, _____

Give the Couchiching Child Care Centre Staff permission to apply the following to my child _____ if/when needed.

	Yes	No
Sunscreen	____	____
Diaper Cream	____	____
Bug Spray	____	____
Hand Sanitizer	____	____
Lip Balm	____	____

_____ _____

Signature of Parent/Guardian Date

Fort Frances Tribal Area
HEALTH SERVICES

CLIENT INFORMATION FORM

Client First Name:	**Client Last Name:**	
Date of Birth (DD/MM/YYYY):	**Community:**	
Gender: ☐ **Male**	☐ **Female**	☐**Undifferentiated**
Health Card #:	**Status Card #:**	
Home Address: **City:** **Postal Code:**	**Mailing Address:** **City:** **Postal Code:**	
Family Doctor/ Nurse Practitioner:	**Family Dentist:**	
My child attends: ☐ **Daycare:**	☐ **School:**	
PARENT/LEGAL GUARDIAN (First Emergency Contact)		
Name:	**Relationship to client:**	
Home #:	**Cell #:**	**Work #:**
PARENT/LEGAL GUARDIAN (Second Emergency Contact)		
Name:	**Relationship to client:**	
Home #:	**Cell #:**	**Work #:**

MEDICAL HISTORY	**Yes**	**No**
Does your child have any health conditions? If yes, please explain:		
Does your child have any allergies? If yes, please explain:		
Is your child taking any medications? If yes, please explain:		
Does your child have any heart problems?		
Does your child have any bleeding problems?		

Does your child have diabetes?		

MEDICAL HISTORY	Yes	No
Does your child have any known hypersensitivities or allergies to colophony (rosin)*? **Colophony (rosin) comes from the sap of coniferous trees such as pines, junipers, firs, and cedars. It can be found in many personal care and beauty products, topical medication, surface coatings, lubricants, adhesives, sealants, diapers, and fluoride varnish.*		
Has your child had dental work done under General Anesthetics (GA) in the past year? If yes, please indicate when:		
Do you have any concerns regarding your child's oral health? Note:		
Are there any other special considerations or concerns related to your child receiving dental care that you would like us to be aware of? Note:		

Parent/Guardian First Name

Parent/Guardian Last Name

DD/MM/YYYY

Parent/Guardian Signature

Fort Frances Tribal Area
HEALTH SERVICES

CONSENT TO SERVICES

Client First Name: **Client Last Name:**	**Date of Birth (DD/MM/YYYY):**

CONSENT TO SERVICES

I give my authorization for the child (name above) to receive any of the following dental services:

- Dental screening;
- Fluoride varnish applications;
- Dental sealants (as required);
- Dental cleaning and/or polishing (as required);
- Interim Stabilization Therapy IST (temporary painless filling as required); and
- Oral health information sessions

Complications or reactions to these procedures are unusual. However, if the child has any complications or reactions to these services, please contact a dental or medical professional.

CONSENT TO RELEASE INFORMATION

Continued on next page..

A. I give my authorization for Fort Frances Tribal Area Health Services (FFTAHS) to collect, obtain, use and disclose information about the child on behalf of Indigenous Services Canada (ISC) for the purpose of the First Nations and Inuit Heath Branch (FNIHB) Children's Oral Health Initiative.

B. I understand that dental program records and data information may be used by FNIHB and/or ISC for management and administration purposes only directly related to FNIHB Children's Oral Health Initiative.

C. I give my authorization for FFTAHS to release and obtain my child's oral health and medical information to/from the dental provider of my choosing in the way of a referral or should I require assistance in finding a dentist and/or scheduling any necessary follow-up appointments upon completion of the COHI dental screening and/or COHI preventative dental treatment(s).

D. I understand that FFTAHS may work in collaboration with the Northwestern Health Unit for the provision of oral health services and give my authorization for FFTAHS to release and obtain the following information about my child to/from the Northwestern Health Unit as needed:
   - Child's name and date of birth
   - Name of school/daycare that child attends
   - Dental screening assessment information if needed to provide or assist in the provision of accessing needed dental care

E. I understand that the personal information of the child is protected under the Privacy Act and the information may only be used or disclosed within the conditions set out in the Act.

This consent will remain in effect until it is withdrawn by a parent, guardian, or authorized representative of the above-named child. I understand that my consent is voluntary and can be withdrawn at any time.

Parent/Guardian Name:	Parent/Guardian Signature:	Date (DD/MM/YYYY):