CHILDMINDING REGISTRATION PACKAGE

ELIGIBILITY

Childminding services are available to elected officials of UBCM members ONLY. The daycare agreement is made directly between the Agency, West Childcare Connection, and the parent.

FEE

There is a nominal fee of $30 per day/per child + GST for the entire day or any partial day. Lunch and snacks are included, as well as short walks and/or activities in the surrounding area outside of the hotel. Breakfast is NOT included. Please ensure that your child is fed before attending.

REGISTRATION

This registration package MUST be returned to Lilliana Kang, Convention Assistant, at lkang@ubcm.ca by AUGUST 30, 2019. Please ensure that all pages of the registration package are completed. Please contact Lilliana if you have any questions.

Please indicate with a ✔ (check mark) the specific dates you require childminding. If you require day care outside of these hours, please arrange directly with West Childcare Connection at 778.991.4443.

✔	Date of Care	Time Available
	Monday, September 23	7:30 am to 5:30 pm
	Tuesday, September 24	7:00 am to 5:30 pm
	Wednesday, September 25	7:00 am to 5:30 pm
	Thursday, September 26	7:00 am to 5:30 pm
	Friday, September 27	7:00 am to 1:00 pm

REGISTRATION & INSTRUCTIONS FOR:		
NAME CHILD #1	**DOB**	**AGE**
NAME CHILD #2	**DOB**	**AGE**
NAME CHILD #3	**DOB**	**AGE**

PARENT(S) /GUARDIAN(S):	**CELL NUMBER (S):** (DURING CONVENTION) **EMAIL:** **HOTEL:**

OTHER INDIVIDUAL WHO MAY PICK UP FROM THE CHILDMINDING ROOM

NAME:

RELATIONSHIP:

CELL NUMBER:

I understand that, under no circumstances, will my child/children be released to anyone other than the individuals listed above:

✍ **Parent's Signature:** **Date:**

CHILDMINDING REGISTRATION PACKAGE

WALKS OR FIELD TRIPS – CONSENT TO PARTICIPATE

I am aware that my child/children will always be accompanied by and will be under the supervision of the West Childcare Connection nannies and I agree/disagree with the following as indicated: (please ✔ decision)

My child/children may participate on short walks and/or activities in the surrounding area (outside of the hotel)

Yes: **No:**

✍ **Parent's Signature:** **Date:**

CHILD SPECIFIC INFORMATION:

ALL ITEMS SUCH AS DIAPERS, FORMULA, SPECIAL DIETARY REQUIREMENTS AND MEDICATIONS (MUST BE IN THEIR ORIGINAL CONTAINERS AND CLEARLY LABELED) ARE TO BE SUPPLIED BY THE PARENT.

In order to assist West Childcare Connection nannies in making your child/children's day comfortable and enjoyable, please indicate her/his routine likes and dislikes relating to:

Food (i.e. eating habits, feeding times)
CHILD #1:
CHILD #2:
CHILD #3:

Suggested lunch/snack items
CHILD #1:
CHILD #2:
CHILD #3:

Nap/Rest Period (How long and when?)
CHILD #1:
CHILD #2:
CHILD #3:

Preferred Activities: (games/books etc.)
CHILD #1:
CHILD #2:
CHILD #3:

Stroller (please state (A) whether required OR (B) whether you will provide one)
CHILD #1:
CHILD #2:
CHILD #3:

Additional Notes:

CHILDMINDING REGISTRATION PACKAGE

AUTHORIZATION TO ADMINISTER MEDICATION

IMPORTANT

ALL MEDICATIONS MUST BE IN ORIGINAL CONTAINERS WITH INSTRUCTIONS.
PRESCRIPTION MEDICATIONS MUST HAVE YOUR CHILD'S NAME ON THE LABEL.

CHILD #1 (FIRST & LAST NAME):

WEST CHILDCARE CONNECTION NANNIES HAVE MY PERMISSION TO:

Administer the following prescription medication/s to my child:
Dosage instructions:

Apply the following creams, lotions or ointments on my child:

Application instructions:

Apply the following sunscreen or sun block on my child:

Application instructions:

CHILD #2 (FIRST & LAST NAME):

WEST CHILDCARE CONNECTION NANNIES HAVE MY PERMISSION TO:

Administer the following prescription medication/s to my child:
Dosage instructions:

Apply the following creams, lotions or ointments on my child:

Application instructions:

Apply the following sunscreen or sun block on my child:

Application instructions:

CHILDMINDING REGISTRATION PACKAGE

CHILD #3 (FIRST & LAST NAME):

WEST CHILDCARE CONNECTION NANNIES HAVE MY PERMISSION TO:

Administer the following prescription medication/s to my child:
Dosage instructions:

Apply the following creams, lotions or ointments on my child:

Application instructions:

Apply the following sunscreen or sun block on my child:

Application instructions:

Parent's Signature: **Date:**

CHILDMINDING REGISTRATION PACKAGE

EMERGENCY CONSENT FORM

CHILD #1 (FIRST & LAST NAME):

DOB (YEAR / MONTH / DAY):

ADDRESS:

PARENT / GUARDIAN'S NAME:

CELL PHONE: **HOME PHONE:**

CHILD'S DOCTOR: **PHONE:**

DATE OF MOST RECENT TENTANUS SHOT:

ALLERGIES / MEDICATIONS:

CARE CARD NUMBER:

Every attempt will be made, by West Childcare Connection nannies, to notify a parent/guardian when a child is ill or needs medical attention. Occasionally, West Childcare Connection nannies will be unable to contact parents and need to get immediate help for the child. Their procedure is to take the child to the nearest emergency service.

Please sign the consent below so that West Childcare Connection nannies can take the appropriate action on behalf of your child and bring this consent to the emergency centre.

I hereby give consent for my child, _____, when ill to be taken to the nearest emergency centre by the West Childcare Connection nannies when I cannot be contacted.

I hereby give consent for my child named above to receive medical treatment.

Parent's Signature: **Date:**

CHILDMINDING REGISTRATION PACKAGE

EMERGENCY CONSENT FORM

CHILD #2 (FIRST & LAST NAME):

DOB (YEAR / MONTH / DAY):

ADDRESS:

PARENT / GUARDIAN'S NAME:

CELL PHONE: **HOME PHONE:**

CHILD'S DOCTOR: **PHONE:**

DATE OF MOST RECENT TENTANUS SHOT:

ALLERGIES / MEDICATIONS:

CARE CARD NUMBER:

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Parent's Signature: **Date:**

CHILDMINDING REGISTRATION PACKAGE

EMERGENCY CONSENT FORM

CHILD #3 (FIRST & LAST NAME):

DOB (YEAR / MONTH / DAY):

ADDRESS:

PARENT / GUARDIAN'S NAME:

CELL PHONE: **HOME PHONE:**

CHILD'S DOCTOR: **PHONE:**

DATE OF MOST RECENT TENTANUS SHOT:

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Parent's Signature: **Date:**

SECTION BELOW TO BE COMPLETED BY PROGRAM ADMINISTRATORS

Reviewed By:	Lilliana Kang	**Yes**:	**Date**:

Anaphylaxis (Life Threatening Allergy) Information Emergency Plan for _____

Facility Name:_____ **Facility Address:**_____

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

DO NOT WAIT FOR SYMPTOMS TO GET WORSE OR NEW SYMPTOMS TO BEGIN

- **GIVE EPINEPHRINE**
- **CALL 911**
- **CALL PARENTS**

CHILD'S ANAPHYLAXIS TRIGGERS ARE:

☐ peanuts ☐ nuts ☐ milk ☐ all dairy ☐ eggs ☐ shellfish ☐ fish
☐ Food additives (list): _____
☐ Insect stings (list): _____
☐ Medications (list): _____
☐ Other: _____

CHILD'S ANAPHYLAXIS SYMPTOMS ARE USUALLY:

☐ swelling (eyes, lips, face, tongue)
☐ hives or itchy skin
☐ cold, clammy, sweaty skin
☐ fainting or loss of consciousness
☐ stomach cramps/diarrhea/vomiting
☐ difficulty breathing/swallowing
☐ tingling of lips/mouth
☐ coughing or choking
☐ flushed face or body
☐ dizziness, confusion
☐ change of voice
☐ heart rate changes (fast/slow)
☐ others (list): _____

CHILD'S EMERGENCY TREATMENT:

☐ Medication is stored where?
☐ Epinephrine auto-injector – expiry date:
☐ Names of staff oriented to plan:
☐ Emergency plan review date (to do yearly):
☐ Field Trip Plans:

Other Instructions:

(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

_____ _____
Primary Care Provider Date

_____ _____
Parent/Guardian Date

_____ _____
Childcare Supervisor/School Personnel Date

Anaphylaxis Care Plan provided as a resource from Vancouver Coastal Health – Jan 2010

Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Asthma Care Plan

Childs Name: _____ **Grade:**_____ **Div:** _____

Facility Name: _____ **Facility 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:

☐ Names of staff oriented to plan:

☐ Emergency plan review date (to do yearly):

☐ 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:

_____ _____
Health Care Provider (ie. Dr/Specialist/NP) Date

_____ _____
Parent/Guardian Date

_____ _____
Childcare Supervisor/School Personnel Date

Asthma Care Plan is provided as a resource from Vancouver Coastal Health – April 2013

Vancouver CoastalHealth
Promoting wellness. Ensuring care.