

TILBURY TOTS EARLY LEARNING CENTRE

REGISTRATION FORM

START DATE: \_\_\_\_\_ WITHDRAW DATE: \_\_\_\_\_

CHILD NAME: \_\_\_\_\_  
(Surname) (Given Name)

DATE OF BIRTH: \_\_\_\_\_ SEX: \_\_\_\_\_  
(mm / dd / year)

ADDRESS: \_\_\_\_\_  
(Include your PO Box)

POSTAL CODE: \_\_\_\_\_ HOME PHONE # \_\_\_\_\_

PARENTS MOTHER/GUARDIAN FATHER/GUARDIAN

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE #: \_\_\_\_\_

CELL PHONE #: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_  
(Invoice will be e-mailed to you once a week)

BUSINESS NAME BUSINESS NAME

BUSINESS ADDRESS BUSINESS ADDRESS

WORK # WORK #

ANYONE OTHER THAN PARENTS ALLOWED TO PICK THE CHILD OR CHILDREN UP

#1 NAME #2 NAME

PHONE # PHONE #

EMERGENCY CONTACT

NAME PHONE #

NAME PHONE #

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PARENTS CONSENT

THIS WILL ONLY BE USED FOR EXTREME EMERGENCIES EVERY ATTEMPT WILL BE MADE TO CONTACT YOU.

NAME OF CHILD: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE: \_\_\_\_\_

I HEAR BY GIVE CONSENT TO HAVE MY CHILD EXAMINED BY THE MEDICAL OFFICER AS NECESSARY.

SIGNATURE OF PARENT OR GUARDIAN: \_\_\_\_\_

SIGNATURE OF WITNESS: \_\_\_\_\_

CHILD HEALTH CARD NUMBER: \_\_\_\_\_

IS YOUR CHILD IMMUNIZATION UP TO DATE? \_\_\_\_\_

PLEASE LIST ALLERGIES, MEDICAL OR EMOTIONAL PROBLEM, IF ANY \_\_\_\_\_

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DOES YOUR CHILD HAVE ANY PROBLEMS WITH SPEECH OR HEARING? \_\_\_\_\_

IS YOU CHILD ON ANY REGULAR MEDICATION? PLEASE PROVIDE DETAILS: \_\_\_\_\_

DOCTOR NAME: \_\_\_\_\_

DOCTOR ADDRESS: \_\_\_\_\_

DOCTOR PHONE NUMBER: \_\_\_\_\_

HOSPITAL PREFERENCE: \_\_\_\_\_

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CONTRACT

I, \_\_\_\_\_ THE PARENT OF \_\_\_\_\_

HAVE READ AND UNDERSTAND THE POLICIES OF TILBURY TOTS EARLY LEARNING CENTRE. BOOKING MY WEEKLY/MONTHLY CALENDAR MUST BE SUBMITTED BY NOON THE THURSDAY PRIOR, ANY CHANGES MADE AFTER NOON FRIDAY WILL BE SUBJECT TO AN EMERGENCY FEE OF \$10.00 PER CHILD.

I HAVE READ AND UNDERSTAND THE POLICIES OF TILBURY TOTS EARLY LEARNING CENTRE FOR HOLIDAYS, VACATIONS AND WITHDRAWAL FROM THE PROGRAM AND GENERAL POLICIES REGARDING THE CARE OF MY CHILD.

I AGREE TO PAY THE AMOUNT SHOWN BELOW FOR EACH CHILD.

I PREFER MY PAYMENTS TO BE MADE WEEKLY: \_\_\_\_\_ BI-WEEKLY: \_\_\_\_\_

PARENTS SIGNATURE: \_\_\_\_\_

SUPERVISOR SIGNATURE: \_\_\_\_\_

**RATES FOR ECOLE ST MARIE & PAINCOUT HUB**

	FULL DAY	HALF DAY (5 HOURS)
INFANTS	\$36.00	
TODDLER	\$31.00	\$23.00
PRESCHOOL	\$29.00	\$21.00
SCHOOL AGE	\$25.00	

**RATES FOR ALL OTHER SITES**

	FULL DAY	HALF DAY (5 HOURS)
INFANTS	\$35.00	
TODDLER	\$30.00	\$22.00
PRESCHOOL	\$28.00	\$20.00
SCHOOL AGE	\$25.00	

HOURLY FOR BEFORE AND OR AFTER SCHOOL \$4.00 PER HOUR PER CHILD.

\*\* Subject to change with a one (1) month notice

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ACKNOWLEDGEMENT OF PERMISSION

DATE: \_\_\_\_\_

I HEREBY GIVE PERMISSION FOR: \_\_\_\_\_

- 1) TO ALLOW PICTURE TAKING AND USE OF PICTURES FOR SCHOOL ACTIVITIES  
(EXAMPLE: NEWSPAPER, VIDEO TAPE OR SPECIAL EVENTS)
- 2) TO GO ON OUTINGS ACCOMPANIED BY APPROPRIATE NUMBERS OF STAFF. THIS IS  
USUALLY FOR WALKS. THERE WILL BE SPECIFIC PERMISSION FOR OTHER OUTINGS, SUCH  
AS FIELD TRIPS, WHERE TRANSPORTATION WOULD BE REQUIRED.
- 3) TO ALLOW THE SUPERVISOR, OR HER DELEGATE, TO CALL A PHYSICIAN, OR SECURE  
MEDICAL CARE IF REQUIRED FOR MY CHILD. I GRANT PERMISSION FOR THIS STAFF TO  
ACT ON MY BEHALF IN ORDER TO PROTECT MY CHILD WHEN I CANNOT BE REACHED OR  
WHEN A DELAY WOULD BE DANGEROUS IN CASE OF ILLNESS OR ACCIDENT. IF A  
MEDICAL EMERGENCY, I GRANT PERMISSION FOR MY CHILD TO BE TRANSPORTED TO  
THE HOSPITAL BY A CAR OR AN AMBULANCE.

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PARENT / GUARDIAN SIGNATURE