



ODYSSEY CHILDCARE 2005
Application for Child Care
CONFIDENTIAL

Date: _____ Date Care Needing to Start: _____
Full Name of **Child**: _____ Birth Date: _____
Days of Week _____ Times: arrival _____ departure _____

Parent(s)

Mother

Name: _____
Address: _____
City: _____ Postal Code: _____
Occupation: _____
Employer /School: _____
Hours of Work: _____ Work Address: _____
City: _____ Postal Code: _____
Home Phone: _____ Email: _____
Work Phone: _____ Cell phone: _____

Father

Name: _____
Address: _____
City: _____ Postal Code: _____
Occupation: _____
Employer /School: _____
Hours of Work: _____ Work Address: _____
City: _____ Postal Code: _____
Home Phone: _____ Email: _____
Work Phone: _____ Cell phone: _____

Emergency Contact

Name: _____
Home Address: _____ Postal Code: _____
Work Address: _____ Postal Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Child **may** be released to (other than the names listed above):

Relationship to child: _____

Child **may not** be released to:

Relationship to child: _____

Note: No child may be released to anyone under the age of 16 years.

Medical Consent

Accidents or illnesses may happen at any time. In the event of an emergency or that you are not available the Agency requests that you give the Provider or staff permission to contact your child's physician or emergency treatment center.

Child's Alberta Health Care #: _____
Physician's Name: _____ Dentist's Name: _____
Office Name: _____ Office Name: _____
Address: _____ Address: _____
Phone #: _____ Phone #: _____

I/we give Odyssey the authority to comply with the instructions of the above named people and/or authorized treatment center in the event of an emergency. I/we give Odyssey the authority to transport my child in the event of an emergency.

Signed: _____ Date: _____

Medical History

*****Please submit copies of your child's immunization records. These can be faxed directly from the Health Unit to Odyssey Childcare Inc. fax number 320-7767.*****

(Please let your provider know when your child's Immunization are updated)

*****Please attach copies of child's Alberta Healthcare card*****

Contagious diseases my/our child has already experienced (ex. Chicken pox):

Any other health concerns and instructions (i.e. Allergies/Asthma):

I/We certify that the above information is correct.

PARENT(S) SIGNATURE: _____ Date: _____

*****If your child is not immunized, please supply a letter from your Physician and/or yourself.
Thank you!*****

Child Profile

Favorite Toy(s): _____

Favorite activities: _____

Discipline Procedures: _____

Fears: _____

Eating Habits:

Please list any food allergies _____

If your child is under 18 months list any foods you are concerned about your child being introduced to _____

Adult Directed: **only if applicable

Bottle(s) _____ Time(s): _____

Baby Food _____ Time(s): Snack _____ Lunch _____ Snack _____

Solids _____ Time(s): Snack _____ Lunch _____ Snack _____

Child Directed:

Drinking: sippy cup _____ cup _____ **please note children cannot be laid down with a cup or bottle

Eating: fingers _____ spoon _____ fork _____

Toileting Habits.

My child: is _____ is not _____ toilet trained.

If Not:

He/She wears: diapers _____ training pants _____ underwear _____

Diapers: disposable _____ Cloth _____

Creams used: Yes _____ No _____ Type: _____

Wipes used: Yes _____ No _____

If Is:

He/She uses the: Toilet _____ Potty Chair _____

He/She needs assistance on the toilet: Yes _____ No _____

He/She wets the bed during Naps: Yes _____ No _____

***Note: You are required to provide enough toileting materials to the provider. The provider is not responsible for washing soiled or dirty clothing.**

Words used for: Bowel movements _____ Urination _____

Toilet routine used at home: _____

My child usually has _____ bowel movements a day and approximately _____ diaper changes.

Daily Routine:

Naps: Yes _____ No _____

Yes: Morning: From _____ to _____

Afternoon: From _____ to _____

You know your child the best. If there are other details about your child that may help your provider to offer better care please outline them in the space provided:

We have the Ages and Stages a developmental screening tool available in the office. Please check if you would like to receive one for your child, one can be given to the provider and one to yourself.

Yes I would like a copy _____ No I would not like a copy _____