



Parent Registration Agreement

805 North Service Road
Mississauga, Ontario
L4Y 1A2

Tel: 905-232-8055 Fax: 905-232-8035
info@thelittlegreenschoolhouse.ca
www.thelittlegreenschoolhouse.ca

Prek-JK JK-SK
a.m./ p.m. a.m./p.m.

Date of Admission
____/____/____
mm / dd / year

Date of Discharge
____/____/____
mm / dd / year

For Office Use Only

CHILD INFORMATION			
Child's Last Name:	Child's First Name:	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	D.O.B. day month year ____/____/____
Child Lives With: mother <input type="checkbox"/> father <input type="checkbox"/> both <input type="checkbox"/> other <input type="checkbox"/> Specify: _____			
PARENT/GUARDIAN INFORMATION			
	MOTHER		FATHER
Name			
Home #			
Cell #			
Email			
Work #			
Occupation			
Home Address	Street: _____ Apt.# _____	Street: _____ Apt.# _____	
	City: _____ Postal Code _____	City: _____ Postal Code _____	
Employer's Name			
Employer's Address			
SIBLING INFORMATION			
	Name		D.O.B.
1.			
2.			
EMERGENCY CONTACTS			
	Name	Home #	Cell #
1.			
2.			
3.			
ADULTS TO WHOM CHILD MAY BE RELEASED TO			
	Name	Home#	Cell #
1.			
2.			
3.			
PEDIATRICIAN OR FAMILY DOCTOR			
Dr.'s Name:			Phone #
Name of Medical Facility:			
Address		City	Postal Code
Mother's Name - Please Print:	Mother's Signature:		Date:
Father's Name - Please Print	Father's Signature:		Date:



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Child's Last Name:	Child's First Name:	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	D.O.B. day month year
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CHILD'S HISTORY

Has your child previously attended day care?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes" : How long? Where:
Does your child have any food allergies:	Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes" please list below:
Does your child have any environmental allergies?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes" please list below:
Does your child require an EPI pen?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes" please specify for what:
Will the EPI pen remain at the centre?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If "No" please specify who will provide the EPI pen to the centre each day:
Does your child have any medical conditions which may require medication?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes" please list and explain below (eg. eczema, asthma, seizures, diabetes etc.):
Does your child require a rest time?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes" please specify what time and for how long.
Does your child follow a special diet?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If "Yes" please specify (eg. vegetarian, celiac, no dairy, etc.)

Previous Communicable Disease (eg. chicken pox, measles, lice, etc.)

Date

Previous Illness or Injury (eg. broken arm/leg, bronchitis, ear infections, etc.)

Date

Special written instructions regarding diet, exercise, medication:

As required by the Region of Peel Health Department, Record of Immunization or completed Exemption Form MUST be submitted prior to child's start date.

Mother's Name - Please Print:	Mother's Signature:	Date:
Father's Name - Please Print	Father's Signature:	Date: