

# ANGEL CARE

**Child Care Centre**

**3-5 Year Old Program**

**Licence # 1381622**

**2023-2024**



**Please attach a recent photo of your child.**

# Angel Care Child Care Centre Fees 2023-24

Our Centre is a registered participant in the BC Child Care Fee Reduction Initiative (CCFRI)

## Full-Time Child Care

**Monday to Friday 7:30am – 5:30pm**

**\$879.00 per month**

**(\$334.00 per month after BC CCFRI)**

\*Please note that the BC CCFRI program is subject to change

**Late Pick-up Fee: \$1 for each minute after program closure (Angel Care closes @ 5:30pm).**

A **\$30.00** non-refundable registration fee is required at the time of application for registration.

All fees are divided into equal monthly payments. There are no reductions for shorter months or holidays.

A minimum of one month's written notice is required for withdrawal from our Child Care Centre.

Upon acceptance to our Child Care Centre, a Family Payment Schedule must be signed, and a direct debit form or void cheque must be on file at the school office.

Students in our Centre are required to wear a QofA crested uniform top.

Short & long-sleeved golf shirts and sweatshirts are available for purchase through our Uniform Store.

We ask children to bring a pair of indoor shoes with non-marking soles to remain at Angel Care for their daily use, as well as their food & snacks for the day.



# Angel Care Child Care Centre

## 3-5 Year Old Program

2085 Maple Bay Rd., Duncan, BC, V9L 5L9

Phone: (250) 701-0433

Email: angelcare@cisdv.bc.ca

### REGISTRATION FORM

ALL INFORMATION MUST BE COMPLETE PRIOR TO ACCEPTANCE OF APPLICATION FOR REGISTRATION

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Our Program is offered year-round on a July – June annual cycle.

Please check off the applicable months of care you require for our 2023-24 program year:

- July 2023  
 August 2023  
 September 2023 – June 2024

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Our Centre hours are Monday – Friday, 7:30 am to 5:30 pm.

Please note your drop-off and pick-up times below:

Drop-off Time: \_\_\_\_\_ Pick-up Time: \_\_\_\_\_

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**CHILD's Information** - Name: \_\_\_\_\_  M  F  
First / Middle / Last

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Name child responds to: \_\_\_\_\_  
Day / Month / Year

Street Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Person(s) with whom the child lives (include siblings): \_\_\_\_\_

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Primary language spoken at home: \_\_\_\_\_ Secondary language: \_\_\_\_\_

Religion/Parish: \_\_\_\_\_ Sibling(s) at Queen of Angels:  Yes  No

Do you intend to register your child in Queen of Angels for Kindergarten?  Yes  No

**MOTHER's Information** - Name: \_\_\_\_\_

Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Email: \_\_\_\_\_

(Please print clearly)

Phone – Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**FATHER's Information** - Name: \_\_\_\_\_

Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Email: \_\_\_\_\_

(Please print clearly)

Phone – Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**Authorization for Pick-up (other than Parents/Guardians):**

Name: \_\_\_\_\_ Home Phn: \_\_\_\_\_ Cell: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phn: \_\_\_\_\_ Cell: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phn: \_\_\_\_\_ Cell: \_\_\_\_\_

Name: \_\_\_\_\_ Home Phn: \_\_\_\_\_ Cell: \_\_\_\_\_

Parent/Guardian Signature for consent to release a child to someone other than a parent:

X \_\_\_\_\_

**Is there anyone who is not permitted to pick-up under any circumstances?**

\*If this is a parent with limited or restricted guardianship, Court Documents are required for our records.

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Custody Agreement details (if any) that you wish us to be aware of: (Attach supporting documents)

\_\_\_\_\_  
\_\_\_\_\_

**Alternate Emergency Contacts (please provide two):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone – Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone – Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**HEALTH Information:**

To best support our students, it is important that our Centre has a full understanding of a child's needs. Has your child ever had any of the following assessments and/or supports?

- Sundrops Centre for Child Development    Physiotherapy    Speech & Language  
 Occupational Therapy    Behavioural Consultant    Supported Child Development  
 Pediatrician    Other: \_\_\_\_\_

**\*\*If yes, please attach documentation\*\***

Is your child able to participate in all areas of the program?    Yes    No

**Does your child:**

- |                                  |  |                             |  |
|----------------------------------|--|-----------------------------|--|
| Have speech/language challenges? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have any allergies?         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have vision challenges?          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Require a special diet?     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have hearing challenges?         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Take medications?           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have other health concerns?      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Have physical restrictions? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**\*Specify/Comment on items ticked "Yes":** \_\_\_\_\_

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Has your child attended daycare/preschool before?    Yes    No

If "Yes", where? \_\_\_\_\_

Does your child have any behaviour concerns? \_\_\_\_\_

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Is there anything else you would like us to know about your child? \_\_\_\_\_

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Please list any illnesses, or communicable diseases your child has had: \_\_\_\_\_

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**IMMUNIZATION Information** – Please either attach a photocopy of immunization record, OR indicate the dates on which immunizations were received below.

**Basic Schedule and Record of Immunizations as submitted by Parent or Guardian**

**1<sup>st</sup> visit – 2 months of age:**

Diphtheria  
Pertussis  
Tetanus  
Polio  
Haemophilus Influenzae Type b (Hib)  
Hepatitis B  
Pneumococcal Conjugate  
Meningococcal C Conjugate

Date (yy/mm/dd)

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**2<sup>nd</sup> visit – 2 months after 1<sup>st</sup> visit:**

Diphtheria  
Pertussis  
Tetanus  
Polio  
Haemophilus Influenzae Type b (Hib)  
Hepatitis B  
Pneumococcal Conjugate

Date (yy/mm/dd)

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**3<sup>rd</sup> visit – 2 months after 2<sup>nd</sup> visit:**

Diphtheria  
Pertussis  
Tetanus  
Polio  
Haemophilus Influenzae Type b (Hib)  
Hepatitis B  
Pneumococcal Conjugate

Date (yy/mm/dd)

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**4<sup>th</sup> visit – 12 months of age:**

Measles  
Mumps  
Rubella  
Meningococcal C Conjugate  
Varicella (chicken pox)

Date (yy/mm/dd)

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**5<sup>th</sup> visit – 12 months after 3<sup>rd</sup> visit:**

Diphtheria  
Pertussis  
Tetanus  
Polio  
Haemophilus Influenzae Type b (Hib)  
Measles, Mumps, Rubella  
Pneumococcal Conjugate\*\*

Date (yy/mm/dd)

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**4 – 6 years of age:**

Diphtheria  
Pertussis  
Tetanus  
Polio  
Varicella (chicken pox)

Date (yy/mm/dd)

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**Other immunizations:**

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**\*If your child has not been immunized, please initial here \_\_\_\_\_**

**Emergency Health Information:**

Care Card Number (This info is a licensing requirement): \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

**Information to readily identify your child in case of an emergency:**

Hair colour: \_\_\_\_\_ Eye colour: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Birthmarks: \_\_\_\_\_

Other identifying features: \_\_\_\_\_

**Emergency Consent**

It is the policy of Angel Care to notify a parent when a child is ill or needs medical attention. Occasionally we cannot contact parents and we need to get immediate help for the child. Our procedure is to call an ambulance to take the child to the nearest hospital. Please sign below so that we can take appropriate action on behalf of your child.

I here by give my consent for my child, \_\_\_\_\_, when ill, to be taken to the nearest hospital by ambulance when I cannot be contacted.

\_\_\_\_\_  
Signature of Parent/Guardian                      Name (Please Print)                      Date

**Please note that a \$30.00 registration fee must accompany this registration form. Registration forms will be accepted once all required information is completed.**

**Office use only**

Date Application Received: \_\_\_\_\_

\$30.00 Registration fee paid:  Cash    Cheque    Debit/Credit    Etransfer

Date Withdrawn: \_\_\_\_\_

## Angel Care Family Agreement:

Please read the Angel Care Parent Handbook carefully before signing this agreement.

I \_\_\_\_\_, parent/guardian of \_\_\_\_\_ (child's name), have been provided with a copy of the Angel Care Parent Handbook. I have read, understand, and agree to the policies and procedures contained within it.

Should any changes be made to these policies, parents/guardians will be notified by Angel Care.

I acknowledge the following:

- Strict adherence to these policies is important for the health and safety of my child, as well as that of other children and staff in our program.
- Failure to follow these policies may result in termination from the Angel Care program.
- I can discuss the care of my child, or any other aspect thereof, and I may do so at the same time with the teachers and management.

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Signature of Parent/Guardian	Name (Please Print)	Date
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## Field Trip & General Release Waiver:

I hereby give permission for my child \_\_\_\_\_ to be taken out of Angel Care for field trips that are within walking distance, as part of our childcare program. Children will be supervised at all times by the Angel Care staff. I understand that an additional permission form is required and will be sent out for all other field trips that are not within walking distance. All mandatory safety precautions will be in accordance with the Provincial Child Care Regulations.

I, for myself, my heirs and estate executors, release **The Bishop of Victoria Corporation Sole**, Island Catholic Schools, and its respective servants, agents, employees from any claims, demands, damages, or actions arising out of or in consequence of any loss, injury or damage to my son/daughter or property.

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Signature of Parent/Guardian	Name (Please Print)	Date
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## Authorization to use Student Photographs:

As part of our school community, your child is involved in many activities throughout the year during which photographs are taken. We occasionally use student photographs for a variety of celebratory and promotional events.

I hereby give permission for photographs of my child \_\_\_\_\_  
to be used by *Angel Care, Queen of Angels Catholic School and Island Catholic Schools, Diocese of Victoria*, for the following purposes:

- Newsletters & bulletin boards
- Publications, promotional material, community projects
- Website/social media
- Group emails to distribute pictures (Early Learning Centre only)
- Pedagogical narrations and other childcare projects (Early Learning Centre only)

**OR**

- None of the Above

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Signature of Parent/Guardian	Name (Please Print)	Date
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## Sunscreen Permission:

I hereby give my consent to have the staff of Angel Care apply sunscreen to my child \_\_\_\_\_ when required. I also agree to the following:

- To supply sunscreen to be used on my child when they begin attending the Centre
- To leave sunscreen at the Centre to be used as needed on my child
- To “re-stock” the sunscreen supply when it is requested by our Centre staff
- To apply sunscreen in the morning prior to drop-off, and Centre staff will re-apply in the afternoon

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Signature of Parent/Guardian	Name (Please Print)	Date
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