Angel Care

Child Care Centre

3-5 Year Old Program

Licence # 1381622

2024 - 2025

Please attach a recent photo of your child.

Angel Care Child Care Centre Fees 2024-25

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

$909.00 per month

($364.00 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

Our Program is offered year-round on a July – June annual cycle.
Please check off the applicable months of care you require for our 2024-25 program year:

- ☐ July 2024
- ☐ August 2024
- ☐ September 2024 – June 2025

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: _____

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): _____

_____

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 <u>not permitted</u> to pick-up under any circumstances?

*If this is a parent with limited or restricted guardianship, <u>Court Documents</u> 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?	☐ Yes ☐ No	Have any allergies?	☐ Yes ☐ No
Have vision challenges?	☐ Yes ☐ No	Require a special diet?	☐ Yes ☐ No
Have hearing challenges?	☐ Yes ☐ No	Take medications?	☐ Yes ☐ No
Have other health concerns?	☐ Yes ☐ No	Have physical restrictions?	☐ Yes ☐ No

***Specify/Comment on items ticked "Yes": _____**

_____

_____

_____

Has your child attended daycare/preschool before? ☐ Yes ☐ No

If "Yes", where? _____

Does your child have any behaviour concerns? _____

_____

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

_____

_____

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

_____

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

1st visit – 2 months of age:	**Date (yy/mm/dd)**
Diphtheria	_____
Pertussis	_____
Tetanus	_____
Polio	_____
Haemophilus Influenzae Type b (Hib)	_____
Hepatitis B	_____
Pneumococcal Conjugate	_____
Meningococcal C Conjugate	_____

2nd visit – 2 months after 1st visit:	**Date (yy/mm/dd)**
Diphtheria	_____
Pertussis	_____
Tetanus	_____
Polio	_____
Haemophilus Influenzae Type b (Hib)	_____
Hepatitis B	_____
Pneumococcal Conjugate	_____

3rd visit – 2 months after 2nd visit:	**Date (yy/mm/dd)**
Diphtheria	_____
Pertussis	_____
Tetanus	_____
Polio	_____
Haemophilus Influenzae Type b (Hib)	_____
Hepatitis B	_____
Pneumococcal Conjugate	_____

4th visit – 12 months of age:	**Date (yy/mm/dd)**
Measles	_____
Mumps	_____
Rubella	_____
Meningococcal C Conjugate	_____
Varicella (chicken pox)	_____

5th visit – 12 months after 3rd visit:	**Date (yy/mm/dd)**
Diphtheria	_____
Pertussis	_____
Tetanus	_____
Polio	_____
Haemophilus Influenzae Type b (Hib)	_____
Measles, Mumps, Rubella	_____
Pneumococcal Conjugate**	_____

4 – 6 years of age:	**Date (yy/mm/dd)**
Diphtheria	_____
Pertussis	_____
Tetanus	_____
Polio	_____
Varicella (chicken pox)	_____
Other immunizations:	
_____	_____
_____	_____

***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 hereby 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.

_____	_____	_____
Signature of Parent/Guardian	Name (Please Print)	Date

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.

_____	_____	_____
Signature of Parent/Guardian	Name (Please Print)	Date

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

_____ _____ _____

Signature of Parent/Guardian | Name (Please Print) | Date

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

_____ _____ _____

Signature of Parent/Guardian | Name (Please Print) | Date