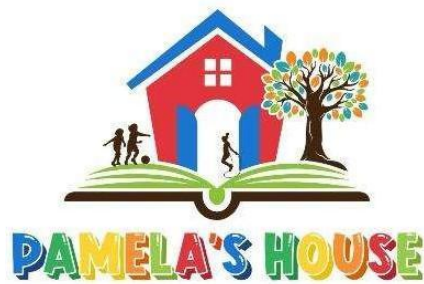


After School Care Program

Child Application Package

PAMELA'S HOUSE



9525 College Street Chilliwack BC

V2P 4S6

604-239-0111

info@pamelashouse.com

Parent Handbook available at pamelashouse.com

Dear Parents/Guardians,

Please **complete all forms** included in this package and return them to the center for review by the Program Director. Once your forms have been reviewed, you will be contacted to schedule an intake interview, provided there is space available in the program for your child(ren) at that time.

Note: The *Medical Administration Consent Form* is only required if your child needs medication to be administered by our staff.

Note: Pamela's House **does not require immunizations** for children to attend our program. However, as part of our **licensing requirements**, Fraser Health requests that we collect immunization records for each child. Providing your child's immunization history is **voluntary** and **does not affect enrollment** in our program.

How to Submit Forms:

You may return the completed forms in one of the following ways:

- **Email:** Scan and send a PDF file of the forms to info@pamelashouse.com.
- **In Person:** Drop them off at 9525 College Street, attention to Kari Pysk – Program Director.

If you have any questions, please contact Kari Pysk at 604-239-0111.

Once your child has been accepted into the program, a **non-refundable \$50 registration fee will be due**. For more information, please refer to the Parent Handbook.

Parent Handbook Acknowledgment Form

Pamela's House

After School Care Program

I, the undersigned parent/legal guardian, confirm that I have received, read, and understand the **Pamela's House Parent Handbook** in its entirety.

I acknowledge that the handbook outlines important information regarding:

- Program policies and procedures
- Code of conduct and expectations
- Health and safety guidelines
- Attendance and pickup procedures
- Fees, payments, and refunds
- Faith-based components of the program
- Emergency plans and communication practices

I understand and agree to support the policies of Pamela's House as outlined in the handbook and recognize that it may be updated from time to time, with notice provided to parents.

Child(ren)'s Name(s):

Parent/Guardian Name (Print):

Parent/Guardian Email:

Signature:

Date: _____

Faith-Based Consent Form

Pamela's House

After School Care Program

9525 College Street, Chilliwack, BC V2P 4S6

Dear Parent/Guardian,

Pamela's House is a Christian-based after school care program where children will regularly participate in **faith-centered activities** such as conversations about Jesus, Bible stories, songs, prayer, and teachings that reflect Christian values and beliefs.

As this is an essential part of who we are and what we offer, **all children enrolled in our program must participate in this aspect of our programming.** If you do not wish for your child to be part of a faith-based environment, we kindly ask that you seek an alternative care program better suited to your preferences.

Please sign below to confirm your understanding and consent.

I, the parent and/or legal guardian of:

Child's Name: _____

☒ I understand that Pamela's House is a Christian after school care program, and I give permission for my child to participate in all faith-based components of the program, including teaching about Jesus.

Parent/Guardian Name (Print): _____

Signature: _____

Date: _____

Photo & Media Consent Form

Pamela's House

After School Care Program

9525 College Street, Chilliwack, BC V2P 4S6

Dear Parents/Guardians,

From time to time, we engage in activities where we would like to capture special moments by taking photos of the children. These photos may be shared on our website and/or Facebook page to keep families informed and to celebrate the fun and learning happening at Pamela's House.

We kindly ask for your consent regarding the use of your child(ren)'s photos. Please indicate your choice below:

Child's Name: _____

☐ **I GIVE** permission for staff at Pamela's House to take photographs of my child(ren) during program activities and to share these images on:

- The center's official website
- The center's Facebook page

☐ **I DO NOT GIVE** permission for my child(ren)'s photos to be taken or shared.

I understand that any images taken will be used solely for program-related purposes and never for commercial use.

Parent/Guardian Name (Print): _____

Signature: _____

Date: _____

Community Care Facilities Licensing Registration Form for Child Care



FACILITY NAME				
FULL NAME OF CHILD			USUAL NAME OF CHILD <i>(if different)</i>	
PERSONAL INFORMATION				
CHILD'S DATE OF BIRTH		GENDER	STARTING DATE	
ADDRESS			FACILITY USE ONLY WITHDRAWAL DATE	
POSTAL CODE	TELEPHONE ()			
PARENT OR GUARDIAN		PARENT OR GUARDIAN		
ADDRESS <i>(if different from above)</i>		ADDRESS <i>(if different from above)</i>		
TELEPHONE ()		TELEPHONE ()		
WORK ADDRESS / ALTERNATE LOCATION		WORK ADDRESS / ALTERNATE LOCATION		
TELEPHONE <i>(Include Local / Extension)</i> ()		TELEPHONE <i>(Include Local / Extension)</i> ()		
CELL PHONE / PAGER ()		CELL PHONE / PAGER ()		
HOURS AT THIS LOCATION		HOURS AT THIS LOCATION		
EMERGENCY HEALTH INFORMATION				
CARE CARD NUMBER				
FAMILY DOCTOR / CLINIC NAME			DOCTOR / CLINIC TELEPHONE ()	
CONSENT FOR EMERGENCY CARE				
I authorize the staff at the child care centre to call a medical practitioner or ambulance and transport child to emergency medical care, in the case of accident or illness of my child(ren), if the parent cannot immediately be reached.			Yes ☐	No ☐
ALTERNATE PERSONS(S) AUTHORIZED TO PICK UP CHILD. Check all that apply <i>(other than parent/guardian listed above, include emergency pick-up)</i>				
Name	Relationship	Telephone	Authorized to Pickup	Authorized to Call in an Emergency
			☐	☐
			☐	☐
PERSONS(S) WHO ARE NOT PERMITTED ACCESS TO MY CHILD				
Name	Relationship	Telephone		

Community Care Facilities Licensing Registration Form for Child Care



CUSTODY OR OTHER LEGAL ORDERS		
Yes ☐	No ☐	If yes, supply a copy of the order to the facility Manager / Licensee
CHILD'S IMMUNIZATION STATUS		
Is your child up to date on immunizations?	Yes ☐	No ☐ Not Immunized ☐
COMMENTS		
HEALTH INFORMATION <i>(attach a separate sheet, if necessary)</i>		
REGULAR MEDICATION(S) AND REASONS FOR <i>(please list)</i>		
ALLERGIES AND TREATMENT OF <i>(please list)</i>		
INJURY(S), ILLNESS(ES) OR OPERATIONS YOUR CHILD HAS HAD AND INCLUDE DATE(S)		
1. Please describe any concern(s) / issues regarding your child's health (seizures, asthma, vision, hearing, etc)		
2. Please describe any concerns you may have regarding your child's development (i.e. behaviour, vision, hearing, speech, language, mobility, etc.)		
3. Describe any specific care instruction regarding 1) and/or 2) above		
OTHER HEALTH CARE PROFESSIONALS INVOLVED IN YOUR CHILD'S LIFE <i>(e.g. occupational therapist / physical therapist)</i>		
ANY OTHER INFORMATION I SHOULD KNOW		
SIGNATURE OF PARENT OR GUARDIAN PROVIDING INFORMATION		
SIGNATURE	PRINT NAME	DATE

Note: This information may be reviewed by Fraser Health Authority Licensing staff as per legislation.

FACILITY USE ONLY *(Facility has provided a copy of the following)*

- | | | |
|-------------------------|------------------------------|-----------------------------|
| 1. Repayment Agreements | Yes ☐ | No ☐ |
| 2. Behavioural Guidance | Yes ☐ | No ☐ |

Community Care Facilities Licensing Registration Form for Child Care



ADDITIONAL INFORMATION ABOUT YOUR CHILD (OPTIONAL)

GROUP EXPERIENCES		
WHAT IS/ARE YOUR CHILD'S FAVOURITE TOY(S) / ACTIVITIES		
HAS YOUR CHILD HAD PREVIOUS PLAY GROUP EXPERIENCE? Yes ☐ No ☐ IF YES, HOW DID HE/SHE ADAPT?		
HOW DOES YOUR CHILD BEHAVE TOWARD OTHER CHILDREN? (E.G. SEEKS OTHERS OUT, FEELS SHY)		
EMOTIONAL		
HOW DOES YOUR CHILD REACT WHEN LEFT WITH UNFAMILIAR PEOPLE AND/OR IN UNFAMILIAR SITUATIONS?		
DOES YOUR CHILD HAVE ANY PARTICULAR FEARS? PLEASE DESCRIBE.		
WHAT SUGGESTIONS DO YOU HAVE THAT WOULD HELP STAFF MAKE YOUR CHILD'S TRANSITION INTO THIS PROGRAM EASIER?		
FAMILY AND GENERAL HOUSEHOLD INFORMATION		
PLEASE LIST THE NAMES OF THE SIGNIFICANT PEOPLE IN YOUR CHILD'S LIFE (E.G. SIBLINGS, GRANDPARENTS, ETC)		
PLEASE DESCRIBE THE GUIDANCE AND DISCIPLINE METHODS USED AT HOME		
PRIMARY LANGUAGE SPOKEN IN THE HOME	OTHER LANGUAGES	
NAME OF ENGLISH SPEAKING PERSON (IF NEEDED)	TELEPHONE	
EATING AND NUTRITION		
LIST YOUR CHILD'S FAVOURITE FOOD		
LIST ANY DISLIKED FOOD		
PLEASE DESCRIBE ANY PARTICULAR EATING PATTERNS		
ARE THERE ANY RELIGIOUS OR ETHNIC OBSERVANCES RELATED TO FOODS?		
SLEEPING		
NAP TIME	HOW LONG TO SETTLE	TIME OF WAKING
BEDTIME	HOW LONG TO SETTLE	TIME OF WAKING
DOES YOUR CHILD TAKE A FAVOURITE COMFORTER (E.G. BLANKET OR TOY) TO BED? Yes ☐ No ☐ IF YES, DESCRIBE AND TELL US IF IT IS "NAMED".		
WHAT IS YOUR CHILD'S MOOD UPON WAKENING?		
TOILETING		
IS YOUR CHILD TOILET TRAINED? Yes ☐ No ☐ PARTIALLY ☐		
PLEASE INDICATE YOUR CHILD'S FREQUENCY OR PATTERNS FOR BOWEL MOVEMENTS		
DESCRIBE ASSISTANCE NEEDED FOR TOILETING		
WHAT "SPECIAL" WORD DOES YOUR CHILD USE FOR:	URINATION: _____	BOWEL MOVEMENTS: _____

Community Care Facilities Licensing Medical Administration Consent



CHILD'S NAME	
MEDICATION	PRESCRIPTION # (if applicable)
DOSAGE OF MEDICATION	HAS THE CHILD TAKEN MEDICATION BEFORE? Yes ☐ No ☐
TIMES OR SYMPTOMS FOR WHEN MEDICATION IS TO BE GIVEN BY CARE PROVIDER	
ANY POSSIBLE SIDE EFFECTS THAT YOU HAVE BEEN MADE AWARE OF BY THE PHYSICIAN OR PHARMACY?	
I authorize the administration of the above medication, in the dosage and frequency stated above to my child. This dosage is consistent with the recommendations of the Physician and/or drug manufacturer. I accept the responsibility of supplying the correct medication in its original container. I will submit a new consent form if there are any changes to this medication, the dosage or the frequency of administration.	
Signature of Parent/Guardian	Date
Telephone	

ADMINISTRATION RECORD (completed by the caregiver administering the medication)			
Date (dd/mm/yyyy)	Time Given (hr / min)	Dosage Administered	Administered by (signature)

Community Care Facilities Licensing Child Immunization Status Declaration



Community Care Facilities (that are licensed to provide care to children are required to have a copy of the Immunization Status on file for each child in care, in the event that an outbreak of a communicable disease should occur. This information will assist in identifying those that may require exclusion because they are not immunized.

This form has been provided to:

- Assist in identifying those children who are not fully immunized and
- Assist licensees in meeting Section 57(2)(a) of the *Child Care Licensing Regulation*.

To be completed by Parent/Guardian:

Child's Name

Date of Birth

Complete Immunization:

- ☐ Record on vaccinations attached
- ☐ Record on vaccinations unavailable

Received immunization in:

Year of last Vaccine

City

Province

(if not in Canada, include Country)

Incomplete Immunization:

- ☐ My child has had some vaccinations
- ☐ My child has no vaccinations
- ☐ I do not know

Parent's/Guardian's Printed Name

Date

Parent's/Guardian's Signatures



EMERGENCY CONSENT CARD

Name of Facility

Child's Name: _____
Surname First Name(s)

Birthdate: _____
Year / Month / Day

Address: _____
Gender of Child: _____

1. Parent's Name: _____
Child lives with: _____

Work Phone: _____
Home Phone: _____

2. Parent's Name: _____
Home Phone: _____

Work Phone: _____
Phone: _____

Emergency Contact: _____
Phone: _____

Child's Doctor: _____
Phone: _____

1. Allergies _____

2. Medications _____

Care Card #: _____

PrintShop #252700 Revised August 2019



EMERGENCY CONSENT CARD

Name of Facility

Child's Name: _____
Surname First Name(s)

Birthdate: _____
Year / Month / Day

Address: _____
Gender of Child: _____

1. Parent's Name: _____
Child lives with: _____

Work Phone: _____
Home Phone: _____

2. Parent's Name: _____
Home Phone: _____

Work Phone: _____
Phone: _____

Emergency Contact: _____
Phone: _____

Child's Doctor: _____
Phone: _____

1. Allergies _____

2. Medications _____

Care Card #: _____

CONSENT FORM

It is the policy of this centre to notify a parent when a child is ill or needs medical attention. In the event we cannot contact you and we need to get immediate help for your child, we require a signed consent to do so.

1. I give consent for my child to be taken to the nearest emergency medical centre when I cannot be contacted.

2. I give consent for my child to receive medical treatment.

Signature of Parent/Guardian

Witness

Date

Picture
of Child

Personal information contained on this form is collected under the Community Care and Assisted Living Act and will be used only for the purpose indicated.

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