BOW VALLEY FAMILY CHILD CARE AGENCY

A Division of Davar Child Care Society
An Accredited Not-For-Profit Society and Registered Charity

Box 8009
Canmore, Alberta T1W 2T8
Phone: 403-609-7392
bowvalley@davarchildcare.org

P R E S C H O O L C H I L D P R O F I L E

Child(ren)'s Schedule of Care

Child's Name:	Male / Female	**Child's Name**:	Male / Female
Birthdate: Year Month Day		**Birth date**: Year Month Day	

Hours of Care Days and Hours that care is required for the week: (**Care is for 10 hours per day/ 5 days per week**) (Please include AM / PM & ECS Times)			**Hours of Care** **If different from first child**: (**Care is for 10 hours per day/ 5 days per week**) (Please include AM / PM & ECS Times)		
	Drop Off Time	**Pick-Up Time**		**Drop Off Time**	**Pick Up Time**
Monday:			Monday:		
Tuesday:			Tuesday:		
Wednesday:			Wednesday:		
Thursday:			Thursday:		
Friday:			Friday:		
Saturday:			Saturday:		
Sunday:			Sunday:		
E.C.S. Times:			**E.C.S. Times:**		
School Name:			**School Name:**		
Application Date:			**Application Date:**		
Date for care to start:			**Date for care to start:**		
Provider Chosen:			**Provider Chosen:**		

Parent / Guardian Information

Child(ren)'s Residence ☐ Yes ☐ No		Child(ren)'s Residence ☐ Yes ☐ No	
Parent:		**Parent#2: and or Non Custodial Parent**	
Address		Address	
Postal Code:	Home Phone	Postal Code:	Home Phone::
Cell Phone:	E-Mail:	Cell Phone:	E-Mail:
Employer:		**Employer**:	
Address:		Address:	
Phone:	Ext:	Phone:	Ext:
E-Mail:		E-Mail:	

Davar Child Care Society
Created September 1998
Revised October 2000;
January 2003; June 2004;
September 2005; August 2007

HEALTH INFORMATION	HEALTH INFORMATION
Child's Name:	Child's Name:
Alberta Health Care Number: □ Copies must be provided	Alberta Health Care Number: □ Copies must be provided
Immunizations: □**Are they up to date?** □ **Y** □ **N** □ Copies or a signed waiver must be provided	**Immunizations:** □**Are they up to date?** □ **Y** □ **N** □ Copies or a signed waiver must be provided
Child's Physician:	Child's Physician:
Address: Phone:	Address: Phone:
□ **Please complete only those issues that are applicable**	□ **Please complete only those issues that are applicable**
Diagnostic Impressions Of The Child:	Diagnostic Impressions Of The Child:
Definition Of Diagnosis:	Definition Of Diagnosis:
Other Agency Support?	Other Agency Support?
Contact Person: Phone:	Contact Person: Phone:
□ **Please indicate if your child experiences any of the difficulties listed below**	□ **Please indicate if your child experiences any of the difficulties listed below**
Allergies to…	Allergies to…
Asthma:	Asthma:
Ear Infections: □ Common □ Uncommon	Ear Infections: □ Common □ Uncommon
Frequent Colds: □ Common □ Uncommon	Frequent Colds: □ Common □ Uncommon
Diarrhea: □ Common □ Uncommon	Diarrhea: □ Common □ Uncommon
Fevers: □ Common □ Uncommon	Fevers: □ Common □ Uncommon
Hearing:	Hearing:
Eyesight:	Eyesight:
Emergency Medical Treatment Release: At any time, due to such circumstances such as an accident or sudden illness, I hereby give my permission for Emergency Medical Treatment to be obtained for my child (ren). Signature:_____	**If there is additional Medical Information that Bow Valley Family Child Care or your provider should be aware of, please request an additional comment form.** **Thank You.**
In the Event of an Emergency	
Name:	Relationship to the child:
Address:	Phone:
Employer:	Phone:
Release of the child (ren) to anyone other than the parent or guardian is strictly prohibited without prior written or verbal phone consent to the day home provider.	Identification must be shown to the provider by the alternate pick-up person.

DEVELOPMENTAL BACKGROUND Has your child been given any sort of health or developmental assessment that Bow Valley Family Child Care Agency and your Provider should know about?	**DEVELOPMENTAL BACKGROUND** Has your child been given any sort of health or developmental assessment that Bow Valley Family Child Care Agency and your Provider should know about?
Child's Name:	Child's Name:
Toilet Trained: □ Yes □ No □Almost	Toilet Trained: □ Yes □ No □Almost
Needs Assistance With: - Eating □ Yes □ No - Dressing □ Yes □ No - Other:	Needs Assistance With: - Eating □ Yes □ No - Dressing □ Yes □ No - Other:
Napping Times:	Napping Times:
Favourite Toys / Activities:	Favourite Toys / Activities:
Dislikes / Fears:	Dislikes / Fears:
Recent events that have happened regarding your child: (i.e. Birth of a sibling, death of a relative or pet, divorce)	Recent events that have happened regarding your child: (i.e. Birth of a sibling, death of a relative or pet, divorce)
Other Comments:	Other Comments:
NAMES OF PERSONS ALLOWED TO PICK UP YOUR CHILD(REN): (as per "Parent Manual Policy")	**NAMES OF PERSONS NOT ALLOWED TO HAVE ACCESS TO YOUR CHILD(REN): (as per "Parent Manual Policy")**

If any of the information contained in the Child Profile or contract should change,
please provide the changes to Bow Valley Family Child Care Agency as soon as possible.