

Campus: \_\_\_\_\_

|                                      |                                    |  |   |
|--------------------------------------|------------------------------------|--|---|
| Name of Child                        |                                    |  |   |
| Preferred Name                       |                                    | Date of Birth MM DD YYYY   | Age   |
| Home Address                         |                                    |  | Gender<br>Male <input type="checkbox"/> Female <input type="checkbox"/> |
| City                                 |                                    | Telephone  |   |
| Province                             |                                    | Postal Code  |   |
| Requested Enrollment Date MM DD YYYY |                                    | How did you hear about us?   |   |
| <input type="checkbox"/> Full Time   | <input type="checkbox"/> Part Time | <input type="checkbox"/> Mon/ Wed/ Alt. Fridays<br><input type="checkbox"/> Tues/Thurs/ Alt. Fridays | Referred by:  |

| FOR OFFICE USE ONLY |          |                     |               |
|---------------------|----------|---------------------|---------------|
| Date of Enrollment  |          | Date of Withdrawal  |               |
| Program             | Schedule | 1st Visit Scheduled | at _____<br>: |
| Campus              |          | 2nd Visit Scheduled | at _____<br>: |

## APPLICATION PROCESS

Date of Application: \_\_\_\_\_

The following is a checklist to expedite the application process:

- A completed application.
- Registration fee of \$250.00 non-refundable.

*Cheques made payable to Childventures Early Learning Academy*

- Visitation and Personal Interview.



Please remember that your requested enrollment date at the time of application is not guaranteed. Every effort will be made to accommodate your family's needs. Approximately 4-6 weeks prior to your anticipated start date, we will contact you to discuss upcoming availability. A security deposit is due upon confirmation of start date. The deposit is refundable based on a one month written notification of withdrawal at which time it will be applied to the last month's invoice.

*If Parents are separated or divorced, please indicate with whom the child is living.  
If there are custody, and/or access issues, legal documentation must be provided to the Centre.*

**FAMILY DATA**

|  |                       |                        |
|--|-----------------------|------------------------|
| <b>PARENT #1 (First &amp; Last Name)</b> |                       |                        |
| <b>If different from child</b>           | <b>Home Address</b>   |                        |
|  | <b>City, Province</b> | <b>Postal Code</b>     |
|  | <b>Home Phone</b>     | <b>Email</b>           |
| <b>Employer's Name</b>                   |                       | <b>Work Phone</b>      |
| <b>Address</b>                           |                       | <b>Alternate Phone</b> |
| <b>City, Province</b>                    | <b>Postal Code</b>    | <b>Occupation</b>      |

|  |                       |                        |
|--|-----------------------|------------------------|
| <b>PARENT #2 (First &amp; Last Name)</b> |                       |                        |
| <b>If different from child</b>           | <b>Home Address</b>   |                        |
|  | <b>City, Province</b> | <b>Postal Code</b>     |
|  | <b>Home Phone</b>     | <b>Email</b>           |
| <b>Employer's Name</b>                   |                       | <b>Work Phone</b>      |
| <b>Address</b>                           |                       | <b>Alternate Phone</b> |
| <b>City, Province</b>                    | <b>Postal Code</b>    | <b>Occupation</b>      |

**SIBLINGS**

|                      |            |
|----------------------|------------|
| <b>Sibling Name:</b> | <b>Age</b> |
| <b>Sibling Name:</b> | <b>Age</b> |
| <b>Sibling Name:</b> | <b>Age</b> |

## HEALTH & MEDICAL INFORMATION

|               |  |           |             |
|---------------|--|-----------|-------------|
| Family Doctor |  | Telephone |             |
| Address       |  | City      | Postal Code |

Please indicate if child experiences or has experienced any of the following:

|  | Yes | No | Unknown | Details   |
|--|-----|----|---------|---|
| Behaviour  |     |    |         |   |
| Seizures   |     |    |         |   |
| Vision/Hearing Difficulties  |     |    |         |   |
| Mobility Difficulties  |     |    |         |   |
| ADHD   |     |    |         |   |
| Asthma   |     |    |         |   |
| Diabetes   |     |    |         |   |
| Dietary Restrictions   |     |    |         |   |
| <b>Allergies</b><br><input type="checkbox"/> Nuts<br><input type="checkbox"/> Bee Stings<br><input type="checkbox"/> Food<br><input type="checkbox"/> Latex<br><input type="checkbox"/> Medication<br><input type="checkbox"/> Other |     |    |         | Epi Pen Required <input type="checkbox"/> Yes <input type="checkbox"/> No |

Is your child currently or has been supported by an outside agency?  Yes  No

