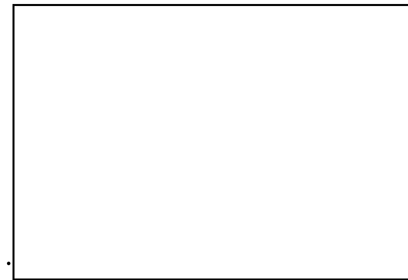
Child Plus
Learning Centre
Day Care and Pre-School

2 FLorida Avenue, Independence City, Gregory Park P.O.
Tele: 988-4888 / 4289962
email: childplus@gmail.com



EARLY CHILDHOOD DEVELOPMENT CENTRE
STUDENT ADMISSION RECORD
REGION 6

REFERENCE NO ………………………… DATE…….…………………..

NAME OD ECDC…………………………………………………………………………

NAME OF CHILD ……………………………………………………………………… SEX………........

DATE OF BIRTH……………………………………………… BIRTH CERTIFICATE NO……………

RELIGIOUS AFFILIATION…………………………………..………………………….………………

LAST ECDC ATTENED……………………………………..…………………………………...…..

REASON FOR LEAVING…………………………………………………………………………….

CLASS PLACED ON ADMISSION…………………............. CLASS ON LEAVING……………………

NO. OF SIBLINGS………………… PLACE IN FAMILY………………… PET NAME………………

MOTHER'S NAME……………………………………………..…..PHONE NO………………………..

ADDRESS…………………………………………………………………………………………………

OCCUPATION…………………………………………………………..WORK NO……………………

FATHER'S NAME…………………………………………………………..PHONE NO…………………

ADDRESS…………………………………………………………………………………………………

OCCUPATION…………………………………………………………WORK NO………………………

GUARDIAN'S NAME……………………………………………………….PHONE NO…………………….

ADDRESS…………………………………………………………………………………………………

OCCUPATION…….……………………………………………….……….WORK NO……………………..…

NAME OF PERSON TO COLLECT CHILD……………………………………………………………..

NB (IN CASE OF CHANGE INFORM ECDC IMMEDIATELY)

IN CASE OF AN EMERGENCY, CONTACT……………………………………………………………..

ADDRESS…………………………………………………………………………………………………

SPECIAL DIETARY REQUIREMENT (IF ANY)…………………………………………………………………

MEDICAL INFORMATION

FAMILY DOCTOR………………………………………………………… PHONE NO………..………………

ADDRESS…………………………………………………………………………………………………

HEALTH FACILITY………………………………………………………………………………….

DOES THE CHILD SUUFER FROM ANY OF THE FOLLOWING? (TICK ALL APPROPRITE BOXES)

ASTHMA ☐ SICKLE CELL ☐ DIABETES ☐ EPILEPSY (FITS) ☐

RMELMATIC FEVER/ HEART DISEASE ALLERGIES ☐ ALLERGIES ☐

OTHER (PLEASE SPECIFY) ☐ ……………………………………………………………………….

SPECIAL NOTE……………………………………………………………………………………………

IMMUNIZATION RECORD

	1ST	2ND	3RD	4TH	5TH
BCG					
OPV/IPV					
DT/ DPT					
MMR					
VARICLLA					
HEPATITS B					
HIB					
PENTAVALENT (DPT, HEP B, HIB)					
OTHER					

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ABOUT YOUR CHILD

1. What is your child favorite toy ,game or activity______________________________________
2. Does your child have any particular mannerism such as thumb sucking or nail biting etc ________
3. If “yes” please state____
4. Does your child have any particular fears such as dogs, lightening, siren, lizard etc _____________
5. If “yes” please state____
6. What method do you use to reward your child’s good behavior______________________________
7. What method do you use to correct your child’s negative behavior ________________________
8. Is your child able eat/ drink y him/herself____
9. What type of food does your child:

- Like____
- Dislike____

10. Is your child toilet trained______________ What word does your child use for toilet___________
11. Does your child usually take naps?____

- How long _______________________ how many times per day? ______________________

12. Any disorders/developmental (slow advance) diagnosed or suspected? _________________________
13. Anything else you would like to inform the center should be aware of regarding your child?

____

____

____

____

____

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Child Care Provisions and Parents Contract

General Information:

CHILD

Child's Name: ____________________

Date of Birth: ____________________

Weight: ____________________ Height: ____________________

MOTHER

Mother's Name: ____________________

Marital Status: Married [ ] Divorce [ ] Single [ ] Widowed [ ]

Home Address: ____________________

____

Home Tel. No.: ____________________

Name of Employer: ____________________

Occupation: ____________________

Work Address: ____________________

Work Telephone No.: ____________________

FATHER

Father's Name: ____________________

Home Address: (if different from above) ____________________ ____________________

____

Home Tel. No.: ____________________

Father's Employer: ____________________

Occupation: ____________________

Work Address: ____________________

Work Telephone No.: ____________________

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PICKUP INFORMATION: (Information on person(s) authorized to pick up your child (ren) from the Centre)

Name: ____

Address: ____

____

Tel. No.: ____

Employer's Name: ____

Occupation: ____

Work Address: ____

Work Telephone No.: ____

Relationship to child: ____

Name: ____

Address: ____

____

Tel. No.: ____

Employer's Name: ____

Occupation: ____

Work Address: ____

Work Telephone No.: ____

Relationship to child: ____

PLEASE NOTE: Under NO circumstances will any child be release to anyone other than those listed above without a written authorization from the parent / guardian.

Emergency Procedures;

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EMERGENCY CONTACT

Name of Contact person if Parent (s) cannot be reached: ______________________________

Address: ____

Tel: No.____

Work Address: ____

Tel. No: ____

Name of Physician in case of medical emergency________________________________

Address: ____

Tele. No: ____

MEDICAL INFORMATION

Any allergies: Yes [ ]   No [ ] If yes please specify________________________________

Prescription Medicine taken regularly: ____

Date of Surgery (If any):_________________   Blood Type: _______________________

Handicapping Conditions: ________________   Special Needs: ______________________

Chronic /recurring Illness: ________________   Special Diets required: ________________

Other information that may be helpful to the Centre and doctor in case of a Medical need:

____

____

IMMUNIZATIONS

Immunization records must be given in at the Centre on or before the child’s first day of care.
PLEASE NOTE: No Child will be accepted in the centre that has not been immunized.

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Emergency Release

Consent to Emergency First Aid & Transportation:

I ___________________________________hereby give permission that my child ____________________, may be given first aid treatment by a staff member at Child Plus Learning Centre. I also give permission for my child to be transported by car, ambulance or aid car to an emergency centre for treatment, and agree not to hold Child Plus Learning Centre and it's employees liable.

Parent's Signature: _______________________________________ Date:_________________________

Consent to Medical Care and Treatment:

In the event that I cannot be contacted immediately, medical or surgical treatment can be administered to my child in the case of an accident or emergency, as prescribed by a treating physician and agree to hold Child Plus Learning Centre and it's employees harmless.

Parent's Signature: _______________________________________ Date:_________________________

PARENTS CONTRACT AGREEMENT

I ____ have read this contract and will comply with all provisions contained herein. I have also agreed to enter into an agreement with Child Plus Learning Centre for the care of my /our child/children ____
With the understanding that we shall work together on behalf of the child.

This agreement will remain in effect until a change is mutually agreed upon in writing or upon termination of our child care service. The agreement is further subject to review and renewal on a yearly basis.

Signed: _________________________________Date: ____________________________
(Parent or Guardian)
Signed: ________________________________ Date: ____________________________
(Child Plus Learning Centre)

Date Child is schedule to arrive at the Centre:____

Date Child is schedule to leave at the Centre:____

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ACCIDENTAL DEATH & DISMEMBERMENT	Amount Paid
• Face Amount	$400,000.00
• Death by Accident Coverage	100%
• Loss of two limbs or sight of both eyes or speech or hearing	100%
• Loss of any one limb or sight of one eye	50%
• Loss of one digit	25%
• Loss of one thumb or index finger	25%

MEDICAL EXPENSES	Amount Paid

As a result of an accident:-

• Ambulance services to hospital	$1000
• Doctors Visit, Dressing, Suturing, Emergency Hospital Bed And other emergency related cost	90%
• Maximum per accident	$120,000.00
• Dental Limits	$10,000.00
• Optical Limited- replacement of broken legs as a result of Accident at the center which required medical attention	$ 1,500.00
• Co-payment claim	10%

HEALTH COVERAGE CONSENT FORM

Detach along broken line, complete this section and submit it to the office along with payment.

Annual premium $ 500.00

CHILD'S NAME: ____

DATE OF BIRTH____

NAME OF PARENT/ GUARDIAN____________________________________

PARENT/GUARDIAN SIGNATURE___________________________________

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APPENDIX II

Early Childhood Institution-Child's Medical Report

Part A TO BE COMPLETED AND SIGNED BY PARENT/ GUARDIAN

NAME OF EARLY CHILDHOOD INSTITUTION ____

CHILD'S NAME ____

DATE OF BIRTH __________________ AGE _____YRS _____MTHS SEX: M ☐ F ☐

ADDRESS ____

____ TELEPHONE NO ______________________________

NAME OF PARENT/ GUARDIAN____

ADDRESS (H)

____

ADDRESS (W)

____

TELEPHONE NO (W) ___________________ (H) ________________ (CELL)______________________

EMERGENCY CONTACT INFORMATION (other than parent/guardian)

NAME__________________________ RELATION _____________ TEL. NO_____________________

ADDRESS____

FAMILY DOCTOR/HEALTH CLINIC____

ADDRESS____

TELEPHONE NO__________________

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MEDICAL HISTORY

Please respond by putting a tick (√) under the appropriate column and record dates of last treatment and remarks for positive responses

Has your child ever been diagnosed or treated for any of the following condition?

Past history	**YES**	**NO**	**DATE**	**REMARKS**
❖ Asthma	( )	( )	______	______
❖ Bronchitis	( )	( )	______	______
❖ Tuberculosis (TB)	( )	( )	______	______
❖ Disorders of the Ears/ Nose Throat	( )	( )	______	______
❖ Rheumatic fever/ Rh Heart Disease	( )	( )	______	______
❖ Heart Disease	( )	( )	______	______
❖ Epilepsy (Fits)	( )	( )	______	______
❖ Mental Disorders	( )	( )	______	______
❖ Learning Disability	( )	( )	______	______
❖ Physical Disability	( )	( )	______	______
❖ Disorders of the Kidney/bladder	( )	( )	______	______
❖ Disorders of Stomach/Bowels	( )	( )	______	______
❖ High Blood Pressure	( )	( )	______	______
❖ Diabetes Mellitus (sugar)	( )	( )	______	______
❖ Leukemia/ Lymphoma	( )	( )	______	______
❖ Typhoid	( )	( )	______	______
❖ Headaches	( )	( )	______	______
❖ Anemia (weak blood)	( )	( )	______	______
❖ Fainting spell/ giddiness	( )	( )	______	______
❖ Excess Tiredness	( )	( )	______	______
❖ Visual disorder	( )	( )	______	______
❖ Hearing disorder	( )	( )	______	______
❖ Hepatitis B	( )	( )	______	______
❖ Meningitis	( )	( )	______	______
❖ Allergies to medication	( )	( )	______	______

List____

❖ Other condition ________________ ( ) ( ) ________________

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HAS YOUR CHILD EVER BEEN ADMINTED TO HOSIPTAL OR HAD SURGERY? YES NO

If yes , please explain for what reason

____
____
____
____

REGULAR MEDICATION TAKEN (IF ANY) ____________________________________

FAMILY HISTORY

Has any family member been diagnosed with the following?

	YES	NO	REMARKS
❖ Asthma	( )	( )	________________________
❖ Allergies	( )	( )	________________________
❖ Diabetes Mellitus	( )	( )	________________________
❖ Tuberculosis	( )	( )	________________________
❖ Cancer/ Tumors	( )	( )	________________________
❖ Sickle Cell Disease	( )	( )	________________________
❖ Mental Disorder	( )	( )	________________________
❖ Migraine	( )	( )	________________________
❖ High Blood Pressure	( )	( )	________________________

I certify that the above information is correct

SIGNATURE ______________________ DATE________________________
(PARENT/ GURADIAN)

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PART B MEDICAL EXAMINATION REPORT – To be completed by a physician

Please give details of findings and verify immunization history

CHILD'S

NAME____02____________________

DATEOF BIRTH ___________________AGE___________HEIGHT________WEIGHT______

BP_________________ URINALYISIS PROTEIN __________________ SUGAR ____________

GENERAL APPEARANCE________________ NUTRITIONAL STATE ________________

POSTURE ______________________ TEETH/GUMS___________________

SKIN _______________________________ HAIR/SCALP______________________

EYES_________________________ VISION R_____________ L ____________________

(INDICATE WHETHER TESTED WITH GLASSES OR NOT)

EARS ____________ NOSE__________ THROAT____________ HEARING__________

BREAST ____________________ THYROID_______________________

RESPIRATORY SYSTEM ____

CARDIVASCULAR SYSTEM____

ABDOMEN/ GI STYSTEM____

CENTRAL NERVOUS SYSTEM____

BONESA AND JOINT ___________________ DEFORMITIES/ DISABILITIES_______________

GENITO URINARY SYSTEM____

Immunization History: Please indicate date

________________________ ________________________ ________________________

DOCTOR'S NAME (WRITTEN) MOJ REG# DATE