



ENROLLMENT FORM

Please complete this form and send it to inventivekidz@gmail.com

START DATE: D / M / YEAR	NUMBER OF DAYS PER WEEK: FULL DAY AM PM MON TUE WED THUR FRI			
DATE OF DISCHARGE: D- M- YEAR				
CHILD'S NAME:				
SURENAME	FIRST NAME	MIDDLE NAME	(NAME USED)	
DATE OF BIRTH(D/M/Y): / /		AGE:	MALE/ FEMALE	
DOES THE STUDENT LIVE WITH: BOTH PARENTS/ MOTHER/ FATHER/ GRAND PARENTS/ OR ETC... PLEASE EXPLAIN? PLEASE PROVIDE ANY COURT ORDERS TO THE SCHOOL.				
IF PARENTS ARE DIVORCED OR SEPARATED, WHO IS THE CUSTODIAL PARENT?				
ADDRESS:				CITY:
POSTAL CODE:		HOME TEL #:		
HOW DID YOU LEARN ABOUT INVENTIVEMINDS ACADEMY? FLYER FREINDS SIGN YELLOWPAGES T.V. WEBSITE PARENTING MAGAZINE PARENTING GROUPS FACEBOOK ON LINE (PLEASE EXPLAIN)				



PARENT/ GUARDIAN INFORMATION

CHILD'S NAME: _____ **DATE OF BIRTH (D/M/Y):** _____

MARITAL STATUS: MARRIED DIVORCED SEPERATED SINGLE				
FATHER'S INFORMATION				
NAME:		WORK TELEPHONE #:		
HOME TELEPHONE #:		CELL TELEPHONE #:		
E-MAIL ADDRESS:		OCCUPATION:		
EMPLOYER'S ADDRESS:				
ADDRESS:		CITY:	POSTAL CODE:	
HOME ADDRESS IF DIFFERENT FROM THE CHILD ADDRESS:				
ADDRESS:		CITY:	POSTAL CODE:	
MOTHER'S INFORMATION				
NAME:		WORK TELEPHONE #:		
HOME TELEPHONE #:		CELL TELEPHONE #:		
E-MAIL ADDRESS:		OCCUPATION:		
EMPLOYER'S ADDRESS:				
ADDRESS:		CITY:	POSTAL CODE:	
HOME ADDRESS IF DIFFERENT FROM THE CHILD ADDRESS:				
ADDRESS:		CITY:	POSTAL CODE:	
<p>Your child will only be released to an authorized person listed on this form (parent/guardian and/or emergency contact). In case of an emergency or an unforeseen circumstance, please indicate the name, address and phone number of any other person/s who you authorize to pick up your child on your behalf. A parent/guardian's verbal authorization for pickup must be received before your child will be released to anyone not listed here. If not received, and we cannot notify you by phone, the child will not be released.</p>				
<p>IN CASE OF EMERGENCY, EVERY EFFORT IS MADE TO CONTACT THE STUDENT'S PARENTS/GUARDIANS. HOWEVER, IF THIS IS NOT POSSIBLE, THE SCHOOL WILL ATTEMPT TO CONTACT THE ALTERNATIVE EMERGENCY CONTACTS LISTED BELOW.</p>				
NAME	RELATIONSHIP	HOME #	WORK #	CELL #



STUDENT MEDICAL INFORMATION

CHILD'S NAME:			
SURENAME	FIRST NAME	MIDDLE NAME	(NAME USED)
ONTARIO HEALTH CARD # (INCLUDING LETTERS AND EXPIRY DATE- OPTIONAL: In case of emergency):			
OTHER INSURANCE (COMPANY AND POLICY #):			
STUDENT'S DOCTOR:		DOCTOR'S TELEPHONE #:	
DOCTOR ADDRESS:			
HAS THIS STUDENT BEEN TESTED FOR ALLERGIES?		YES / NO	
HAS THE STUDENT BEEN DIAGNOSED WITH ALLERGIES?		YES / NO	
IF YES PLEASE DESCRIBE:			
DOES THE STUDENT REQUIRE AN EPI-PEN?		YES/ NO	
(IT IS THE RESPONSIBILITY OF THE PARENT/ GUARDIAN TO ENSURE THAT THE STUDENT HAS A CURRENT DATED EPI-PEN AT SCHOOL AND IT IS RECOMMENDED THAT ALL STUDENTS REQUIRING AN EPI-PEN HAVE TWO EPI-PENS OR A DUAL INJECTION EPI-PEN).			
IF YES, PLEASE COMPLETE THE "AMINISTRATION OF PRESCRIPTION MEDICATION FOR ANAPHYLAXIS " ATTACHED			
PLEASE PROVIDE A MEDICAL NOTE FROM THE STUDENT'S DOCTOR DESCRIBING THE NATURE OF THE ALLERGY.			
IMMUNIZATION:			
The Health Unit now requires that we have a photocopy of your child's recent immunization record in our files. Please include a photocopy with this registration form. If you do not have the records, a copy can be obtained from your local health unit.			
HAS THE STUDENT BEEN DIAGNOSED WITH ASTHMA?		YES/ NO	
DOES THE STUDENT REQUIRE AN INHALER FOR ASTHMA?		YES/NO	
(IT IS THE RESPONSIBILITY OF THE PARENT/ GUARDIAN TO ENSURE THAT THE STUDENT HAS A CURRENT DATED INHALER AT SCHOOL.)			
DOES THE STUDENT CARRY ANY KIND OF MEDICAL PROBLEM, SOCIAL, EMOTIONAL PROBLEMS OR DISABILITIES, PLEASE EXPLAIN AND EXPAND?			
<p>EMERGENCY CONSENT: It is our policy to notify a parent when a child is ill or needs medical attention while in our care. Occasionally, we cannot contact a parent or the 3 emergency contact numbers and we need to get immediate help for the child. Our procedure is to take the child to the nearest emergency service. Please sign below so that we can take appropriate action on behalf of your child. I HEREBY GIVE MY/OUR CONSENT FOR MY/OUR CHILD _____ WHEN ILL/INJURED, TO BE TAKEN TO THE NEAREST EMERGENCY CENTER BY THE STAFF OF MY CHILD'S SCHOOL WHEN I/WE CANNOT BE CONTACTED. I CONSENT TO AN AMBULANCE BEING CALLED TO TRANSPORT THE CHILD, IF NECESSARY. I FURTHER AGREE TO PAY ALL COSTS INCURRED FOR TRANSPORT.</p>			
PARENTS / GUARDIAN SIGNATURE:		PARENTS/ GUARDIAN SIGNATURE:	
DATE:		DATE:	



PHOTOGRAPHIC WAIVER

DURING THE SCHOOL YEAR, NUMEROUS PHOTOGRAPHS ARE TAKEN TO DOCUMENT DAILY CLASSROOM ACTIVITIES, TRIPS, EVENTS AND SPECIAL ACTIVITIES. SOME OF THESE PHOTOGRAPHS ARE USED FOR SCHOOL PURPOSES, SUCH AS BULLETIN BOARD, DISPLAYS, YEARBOOKS AND IMKA NEWSLETTER.

Date: _____ Child's First and Last Name: _____

Name of Parent: _____

Parent Signature: _____

To Inventive Minds Kidz Academy I _____

Residing at _____ grant and release to Inventive Minds Kidz Academy to use photographs, and or videotapes in which I and /or my children appear for use in the following category:

CATEGORY	Yes / No	Parent/ Guardian Initial
This Center's Décor		
The annual report		
Staff training purpose		
Publicity brochures		
Newsletter		
Any materials and articles promoting InventiveMinds Kidz Academy, its programs and membership.		

In the event that any of these films, photographs, and videotapes are to be used for any other purposes, it is understood and agreed that my consent shall be obtained prior to any use.



ACADEMIC/ DAILY ROUTINE HISTORY

CHILD'S NAME: _____ DATE OF BIRTH (D/M/Y): _____	
HOME LANGUAGES:	DOES THE CHILD SPEAK ENGLISH? YES/ NO
DO YOU WANT YOUR CHILD TO NAP IN THE AFTERNOON?	YES/NO
HOW DO YOU SOOTH YOUR CHILD FOR SLEEP TIME? (EXPLAIN)	
DOES YOUR CHILD HAVE NIGHTMARE OR SLEEP WALKS?(EXPLAIN)	YES/NO
DOES YOUR CHILD HAVE ANY SPECIAL LEARNING, BEHAVIOURAL OR PHYSICAL DIFFICULTIES? (WE ASK THIS IN ORDER TO BETTER KNOW AND CARE FOR YOUR CHILD)(EXPLAIN)	
YES/NO	
LIST ALL FOODS THE STUDENTS SHOULD NOT EAT FOR RELIGIOUS/DIETRY REASONS.	
IS YOUR CHILD TOILET TRAINED?	YES/NO
ARE YOU TOILET TRAINNING YOUR CHILD?	YES/NO
HOW OFTEN WOULD YOU LIKE US TO TAKE YOUR CHILD TO WASHROOM TO SUPPORT HIS OR HER TOILET TRAINNING?	
EVERY HALF HOUR	EVERY HOUR
BEFORE BEDTIME	AFTER BEDTIME
OTHER (EXPLAIN)	
PLEASE INDICATE ALL THE AGES OF SIBLINGS. ALSO, IF YOUR CHILD IS THE FIRST, MIDDLE OR LAST CHILD OF THE FAMILY.	
IS THIS YOUR CHILD FIRST TIME IN A LEARNING CENTER?	YES/NO
PLEASE LIST NAMES & ADDRESSES OF ANY OTHER PREVIOUS SCHOOLS (MAXIMUM 3):	
1.	
2.	
3.	
PLEASE SPECIFY ANY THING YOU WISH THE TEACHERS KNOW ABOUT YOUR CHILD DAILY ROUTINE?	

EMERGENCY CONTACT CARD

Full First and Surname Of the Child: _____	Date Of Birth: _____
MOTHER FIRST/ LAST NAME: HOME ADDRESS: WORK ADDRESS: WORK NUMBER: HOME: CELL:	FATHER FIRST/LAST NAME: HOME ADDRESS: WORK ADDRESS: WORK NUMBER: HOME: CELL:
STUDENT'S DOCTOR: DOCTOR ADDRESS:	DOCTOR'S TELEPHONE #: POSTAL CODE:
ONTARIO HEALTH CARD # (INCLUDING LETTERS AND EXPIRY DATE):	
SPECIAL DIETARY/ ALLERGIES /MEDICAL CONDITION OR NOTES: _____ _____ _____	IN CASE OF EMERGENCY, EVERY EFFORT IS MADE TO CONTACT THE STUDENT'S PARENTS/GUARDIANS. HOWEVER, IF THIS IS NOT POSSIBLE, THE SCHOOL WILL ATTEMPT TO CONTACT THE ALTERNATIVE EMERGENCY CONTACTS LISTED BELOW. FIRST NAME: _____ SURENAME: _____ WORK: _____ HOME: _____ CELL: _____ ADDRESS: _____ Postal Code: _____ RELATIONSHIP TO THE CHILD:
Has child has had any communicable disease? If yes what? _____	

SUNSCREEN CONSENT FORM

Childs Name: _____

Date of Birth: _____

As the parent/guardian of the above child, I recognize that too much exposure to UV rays may harm my child's health. Therefore, I give permission for the staff at Inventiveminds kidz Academy to apply a sunscreen product provided by me that is broad spectrum with SPF 15 or higher to my child, as specified below when he/she will be outside. I understand that sunscreens will be applied to exposed skin, including but not limited to the face (except eyelids), tops of ears, nose, bare shoulders, arms and legs.

I have checked and initialed below all applicable information regarding the use of sunscreen on my child:

- I have clearly marked the sunscreen with my child's name.
- The sunscreen I have provided is nut free.
- I do not know of any allergies my child has to sunscreen.
- My child is allergic to some sunscreen. Please use ONLY the following brand type of sunscreen I have provided for my child.
- For medical or other reasons, please Do Not apply sunscreen to the following areas of my child's body.

Parent Name: _____

Parent Signature: _____

Date: _____

CHILD CARE CONTRACT/ PROGRAM STATEMENT/ PARENT HAND BOOK

I HAVE READ, UNDERSTOOD AND CONFIRM TO HAVE RECEIVED A COPY OF THE PARENT HAND BOOK (FEES, CLOSURE DATES AND POLICIES AND PROCEDURES OF CCEYA ACT AT INVENTIVEMINDS) , I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE CONTRACT, PROGRAM STATEMENT AND PARENT HANDBOOK.

Student's Name: _____

Signature of Parent: _____

Name of Parent: _____

Signature of Supervisor: _____

Date: _____

CONSENT TO OBTAIN EMERGENCY MEDICAL CARE ON BEHALF OF THE CHILD

I HEREBY GRANT PERMISSION FOR THE OPERATOR, OR DESIGNATE, OF THIS CHILD CARE CENTRE TO TAKE WHATEVER STEPS ARE NECESSARY TO OBTAIN EMERGENCY MEDICAL CARE IF WARRANTED.

THESE STEPS MAY INCLUDE, BUT ARE NOT LIMITED TO THE FOLLOWING:

- 1- ATTEMPT TO CONTACT A PARENT OR GUARDIAN.**
- 2- ATTEMPT TO CONTACT THE CHILD'S PHYSICIAN.**
- 3- ATTEMPT TO CONTACT EMERGENCY CONTACT PERSON.**

IF WE CANNOT CONTACT THE PARENT OR GUARDIAN, THE CHILD'S PHYSICIAN OR AN EMERGENCY CONTACT PERSON, WE WILL DO ANY OR ALL THE FOLLOWING;

- 1- CALL ANOTHER PHYSICIAN.**
- 2- CALL AN AMBULANCE.**
- 3- HAVE THE CHILD TAKEN TO THE EMERGENCY DEPARTMENT OF THE HOSPITAL, IN THE COMPANY OF A STAFF MEMBER.**

ANY EXPENSES INCURRED UNDER CIRCUMSTANCES LISTED ABOVE WILL BE BORNE BY THE CHILD'S FAMILY.

THE CHILD CARE CENTRE WILL NOT BE RESPONSIBLE FOR ANY INCIDENT THAT MAY OCCURE AS A RESULT OF FALSE INFORMATION GIVEN AT AND AFTER THE TIME OF ENROLMENT.

PARENT SIGNATURE: _____

WITNESS SIGNATURE: _____

DATE: _____

CONSENT FROM FOR WALKING EXCURSIONS ONLY

RE: _____

CHILD'S FULL NAME

I HEREBY GIVE CONSENT TO INVENTIVEMINDS KIDS ACADEMY TO LEAVE THE PREMISES OF THE DAYCARE FROM TIME TO TIME TO PARTICIPATE IN EXCURSIONS TO PLACES OF INTEREST PLANNED AS PART OF MY CHILD'S PROGRAM. IT IS UNDERSTOOD THAT MEMBERS OF THE STAFF WILL PROVIDE CONSTANT SUPERVISION.

NOTE: FOR ANY SPECIAL FIELD TRIPS THAT IMKA WILL GO WITH THE CHILDREN, PARENTS WILL BE GIVEN ADVANCED NOTICE AND WILL RECEIVE A SEPARATE PERMISSION FORM OUTLINING THE DETAILS OF THE FIELD TRIP.

PARENT SIGNATURE

DATE

IMMUNIZATION RECORD

TO BE COMPELETED BY PARENT PRIOR TO ADMISSION

CHILD'S NAME: _____

ONTARIO HEALTH CARD NUMBER: _____

DATE OF BIRTH: _____ **(M/D/YEAR) GENDER:** _____

PARENT OF GAURDAIN:
NAME: _____ **LASTNAME:** _____ **RELATION SHIP TO THE CHILD:** _____

ADDRESS: _____ **POSTAL CODE:** _____ **CITY:** _____ **PROV:** _____

HOME CONTACT NUMBER: _____ **BUSINESS CONTACT NUMBER:** _____

WORK ADDRESS: _____ **POSTAL CODE:** _____ **CITY:** _____ **PROV:** _____

UNDER THE CCEYA ACT IN ORDER TO ATTEND ONTARIO CHILD CARE FACILITIES, CHILDREN MUST HAVE PROOF OF IMMUNIZATION AGAINST ALL REQUIRED PUBLICLY FUNDED ROUTINE IMMUNIZATION SHCEDULE IN ONTARIO.

ENCLOSE A COPY OF THE CHILD'S IMMUNIZATION RECORD AND RETURN TO IMKA PRIOR TO ADMISSION.

EMERGENCY MEDICAL CARE

I HEREBY GRANT PERMISSION FOR IMKA TO SECURE THE NECESSARY EMERGENCY MEDICAL TREATMENT NEEDED BY MY SON/DAUGHER _____ IN THE EVENT THAT I CANNOT REACHED TO OTHERWISE AUTHORIZE THE CENTER.

DATE: _____ **PARENT SIGNATURE:** _____

STUDENT FILE CHECKLIST

ITEM	CHECK
HOME ADDRESS	
HOME PHONE NUMBER	
CHILD'S DATE OF BIRTH	
MOTHER'S WORK ADDRESS	
MOTHER'S WORK PHONE NUMBER	
FATHER'S WORK ADDRESS	
FATHERS WORK PHONE NUMBER	
PHYSICIAN'S NAME	
PHYSICIAN'S ADDRESS	
PHYSICIAN'S PHONE NUMBER	
EMERGENCY CONTACT NAME	
EMERGENCY CONTACT ADDRESS	
EMERGENCY CONTACT PHONE NUMBER	
ALLERGIES	
MEDICATION	
SPECIAL DIET	
HISTORY OF COMMUNICABLE DISEASES	
WRITTEN INSTRUCTION CONCERNING EMERGENCY MEDIAL TREATMENT	
CONFIRMATION OF RECEIVE OF PARENT HANDBOOK, CONTRACT AND MISSION STATEMENT	
SUNSCREEN CONSENT FORM	
CONSENT FORM FOR VIDEO AND PHOTOGRAPHY	
CONSENT FORM FOR WALKING EXCURSIONS	
COMMENCEMENT DATE	
WITHDRAWL DATE	
SIGNATURE FROM PARENTS (WHERE NEEDED)	

Amendment to the terms of the contract commencing September 15/2016.

Term Fee:

Inventiveminds Kidz Academy carries 4 term in a year. (Fall, Winter, Spring, Summer) There is a monthly term fee charged to families account if they wish for there children to participate in educational and Fun activities. These fee are used for the different third party events that are hosted with in the center for the children during the operational hours. The term fee may vary depending to the term and the activities set for the children.

Parents have the opportunity to participate and pay a fee for the activities or have the opportunity not to participate. Children that do not participate will be separated from other children and will have the opportunity to enjoy the day to day development activities. Please note all subsidized children are allowed to participate with no fee.

I _____ (Parent Name) consent that I wish for my child to participate in the educational and fun third party activities. Parent Initial (_____)

I _____ (Parent Name) do not wish to participate in the educational and fun third activity. Parent Initial (_____)

Work Shop Fees:

Inventiveminds Kidz Academy carries educational workshop for parents that they wish to become active in their children social, emotional, cognitive development. There is a fee associated with the workshop for parents. Please note that at times some of the workshop will be free of charge.

Parents have the opportunity to participate and pay per workshop or have the opportunity not to participate.

I _____ (Parent Name) consent that I wish to participate in the educational workshop hosted at Inventiveminds Kidz Academy. Parent Initial (_____)

I _____ (Parent Name) do not wish to participate in the educational workshop hosted at Inventiveminds Kidz Academy. Parent Initial (_____)

Extra Curricular Fee

Inventiveminds kids Academy carries professional artistic and athletic activities. These activities may vary per term. Parents have the opportunity to register their children for the activity or not to register. Parents are informed via these term activities by newsletters to select and choose the activity they wish.

Subsidized families are allowed to choose 1 artistic and 1 athletic activity free of charge per term.

I _____ (Parent Name) consent that I wish for my child to participate in the extra curricular activities. Parent Initial (_____)

I _____ (Parent Name) do not wish to participate in the extra curricular activities. Parent Initial (_____)

I _____ have read and fully understood the terms added to my contract.

Parent Signature: _____

Witness Signature: _____

Date: _____

Amendment to the terms of THE PARENT HANDBOOK commencing September 15/2016.

This is to acknowledge that I _____ (Parent Name) have received original copy of new parent handbook on September 15/2016. I acknowledge that I fully understand my obligations and right.

In my handbook there is the following new information related to the new CCEYA Act changes and the operational new information.

- 1- Mission statement
- 2- Fees
- 3- Additional Fees
- 4- Extra curricular Activity Fee
- 5- Work Shops
- 6- Waiting list policy

Parent Name: _____

Parent Signature: _____

Date: _____

Sleep Monitoring and Sleep Routine

Having a routine before going to bed helps you sleep well. Even if you do not follow your routine every time, you are teaching your child's body and their mind to wind down before sleeping.

Under the CCEYA Act IMKA is required to have a detailed understanding of your child sleep routine and to ensure proper monitoring is in effect. The following information will help guide the staff to ensure your child wellbeing is met.

If a family's beliefs or practices are in conflict with CCEYA act, then the service will not endorse an alternative practice, unless the service is provided with written advice from a medical practitioner. For example: only in rare medical conditions is it necessary for a baby to sleep on its stomach or side. The service will only endorse this practice if the baby's medical practitioner supports the alternative sleeping practice in writing with sound medical reasons.

Describe your child bedtime routine?

Please choose from the following below list to add if necessary.

Your routine can include a couple of activities like having a bath, brushing your teeth, reading, listening to soft music, closing the curtains, etc.

How do you make your sleep environment welcoming? Please circle around the list that fits your daily routine.

-As dark as possible even for a day time rest.

- Free of noise.

- soothing music in the background

- Inviting and comfortable. Please expand?

- A few degrees cooler/ warmer than the rest of the house. Circle around the correct response.

- Free of electronic devices like a digital clock, television, computers, phones, etc

Physical body description during sleep time? For example ; Sleeping on their back, stomach and etc... Please note that based on Joint statement on safe sleep "Preventing sudden Infant Deaths in Canada". IMKA will not endorse sleeping on side or stomach for any child from Infancy- Preschooler based on CCEYA Act regulation 137/15 . If needed for any medical reason must provide a dr. note.

Child Sleeps While; Please circle if applicable.

1- Breastfeeding

2- Rocking

3- Stroller walk

Please note that based on Joint statement on safe sleep "Preventing sudden Infant Deaths in Canada". IMKA will not endorse the above methods for sleep at any time.

Parent Name: _____ Parent Signature: _____ Date: _____

IMKA Infant Room Policies

Ontario regulation 137/15

42(1)

Each infant under one year old who receives care at a child care centre is fed in accordance with written instructions from a parent /guardian of the child.

Parents are required to bring in all food and beverages for children who are unable to eat table food and provide written instructions with regard to feeding. All food brought into the daycare must be labeled and in appropriate containers to heat in the microwave and serve. Special instructions for feeding infants should be in writing specifying times and amounts to be fed. **Please remember that the daycare is a nut free environment!**

Children who are able to eat table food are provided with their meal according to the menu posted in the classroom. The centre provides nutritionally adequate meals and snacks which follow Canada's Food guide requirements. Substitutions are posted to notify parents/guardians of the change. Any special or parental preference diets must be arranged at enrollment with the Supervisor.

Infants under one year are fed following the written instructions provided by the parent/guardian and it is important to note that bottles will not be given while the infant is lying down. Bottles are held at a 45 degree angle with an educator holding the bottle until the infant is able to do this independently.

Our educators are responsive to the children's cues of hunger, fullness, intake of milk/formula and food. We encourage the child to eat, but never force food. Water is available at all times.

The food preparation area within the room is in accordance with local public health requirements and bottles and food can be accessed and prepared without staff leaving the room.

Introduction of solid foods and new types of foods are offered to correspond with each individual child's development, with consistent communication with parents.

Our educators encourage the children to practice self-help skills and encourage interesting conversation and modeling language related to the food and drink to support communication development.

Parents are required to bring in a schedule of their day at home, so that the childcare can follow the child's routine. Changes to their routine will be noted on the daily report and discussed with parents. Please advise the staff of any changes at home – child not sleeping, teething etc. The child care staff are required to visually observe the children while sleeping to ensure they have no signs of respiratory distress.

I (Parent Name) _____ have reviewed IMKA food menu for infant and I would like to provide my child _____ (Child's Name) IMKA food. _____ Parent Initial

I (Parent Name) _____ have reviewed IMKA food menu and do not wish for my child _____ to eat IMKA food menu, I will be bringing my own food for my infant. And will complete the In-home report form daily and submit to the supervisor daily. All foods are nut free.

Subsection 4.13 Sleep Policies and Supervision

Children under 12 months of age will always be placed on their backs to sleep as recommended in the Joint Statement of Sleep Health Canada, unless the child's doctor recommends otherwise in writing. Once the child is able to roll over themselves we will allow them to choose their own sleep position, however when we place them in their crib, we will always place them on their back. These provisions are in place to reduce the risk of harm or injury.

It is recommended that children under 12 months have nothing in their crib. Please ensure your child has a one piece sleeper for rest time if under 12 months of age. Infants over 12 months are able to have a thin breathable blanket for rest time.

Outdoor Play Infants

Parents should be aware that all the children are required to go out in the playground for physical exercise one hour in the morning and one hour in the afternoon, weather permitting. (The Canadian Pediatric Society recommends not going out for play if temperature or wind chill is -27 Celsius or -16 F.) It is necessary therefore, that your child always has the appropriate clothing for the season to go outdoors in the playground (Winter: Snow suits, warm hat to cover the ears, water proof mittens, warm/waterproof boots and in Summer: a wide brimmed hat that covers the child's neck, face and ears and protective light weight clothing). We suggest parents apply suntan lotion before arriving at the Child Care and provide us with a labelled bottle of sunscreen to apply throughout the day.

Proper shoes must be worn at all times. Always leave a pair at the daycare with your child's name on them. Spare clothes must be kept for the child in case of accidents, please ensure all clothing is labelled with your child's name! Blankets and soft sleep toys (labelled with your child's name) must be taken home every Friday to be washed. These remain in their crib for the week.

Ill Child

In compliance with York Regional Health Department it is our policy that children exhibiting any signs of ill/health or communicable disease be excluded from the daily program. They must be symptom free for 24 hours before returning to daycare and able to go outdoors for their two hours of physical activity in the playground.

Every effort is made to make slow transitions into or from the infant room. The transition from the infant room to the toddler room can be made before 18 months of age. Any "early" moves are made in consultation with the teachers and the parents.

Please sign below to indicate you have read and understand the Infant Room policies.

Child's Name

Date

Parent's Name

Parent's Signature

Immunization Record

I _____ parent of _____ Child's Name understand my obligation to update the office off all the immunization of my child and provide the record immediately to the office. If immunization records are not provided base on Ontario Immunization Chart, IMKA will suspend my service until proper immunization is submitted. All up to date immunizations can be emailed to inventivekidz@gmail.com.

I am confirming to have received a copy of Ontario immunization chart.

Parent Signature: _____

Date: _____

INDIVIDUAL CHILD EATING AND SLEEP TIME ROUTINE AT HOME;

CHILD'S NAME: _____

DATE OF BIRTH: _____

SLEEP SCHEDULE TIME BLOCKS (PLEASE INDICATE THE TIME BLOCKS YOUR CHILD SLEEPS)

A.M: _____

MID DAY: _____

AFTERNOON: _____

EATING ROUTINE TIME BLOCKS AT HOME;

MILK

A.M: _____

MID DAY: _____

AFTERNOON: _____

SOLID FOOD:

A.M: _____

MID DAY: _____

AFTERNOON: _____

WATER INTAKE:

A.M: _____

MID DAY: _____

AFTERNOON: _____

PARENT NAME: _____ **SIGNATURE:** _____

IMKA PARENT MEAL TIME QUESTION

Child's Name: _____

Date of Birth: _____

Age of the Child: _____

Start Up date: _____

Primary Physician: _____

1-Describe your child eating?

Bottle Feeding

Pureeing food

Cutting up into small pieces

Mashed soft table food

Regular liquid

Thick liquid

Regular table food

2-Describe in detail which type of feeding you have introduced to your child and if you are in transition from bottle feeding to pureeing food or if from pureeing food to cutting up into small pieces or etc...?

3-How often does your child eat and drink?

Food Intake _____ serving Milk Intake _____ serving Water Intake _____ serving

4-Please list all the Vegetables & Fruit introduced to your child:

5-Please list all the Grain Products introduced to your child;

6-Please list all the Milk and Alternatives introduced to your child:

7-Please list all the Meat and Alternatives introduced to your child;

8-Does your child prefer the food in a certain temperature?

Cold warm room temperature hot

9- Who normally feeds your child?

10- Where is the child fed? On your lap or high chair or chair?

____ Initial

11-Does your child have any food allergies that you are aware of?

12- Is there any form of allergies in food in your family? Please specify any food allergies?

13- Does your child have any problem or symptoms while eating or after eating?

a- Gagging;(Please describe)

b- vomiting ;(Please describe)

C - Constipation: (Please describe)

d-Gastroesophageal Reflux; (Please describe)

Additional Comments:

Parent Singnature:_____

Date:_____