

EKSA 0 KON:'A
CHILDCARE CENTRE
APPLICATION

Sponsoring organization - Mohawks of the Bay of Quince

Date Enrolled:

Date Withdrawn:

1. CARE REQUIRED:

Monday Tuesday Wednesday Thursday Friday

2. HOURS OF CARE REQUIRED:

am

pm

3. CHILD'S NAME: _____

Date of Birth: _____

Band No.: _____

4. MOTHER/ GUARDIAN: _____

Address: _____

Phone #: _____

Place of employment: _____

Work #: _____

5. FATHER'S NAME: _____

Address if different: _____

Phone #: _____

Place of employment: _____

Work #: _____

6. MARITAL S 'ATUS OF PARENTS: _____

Married Single Divorced Separated Widowed

7. EMERGENCY 1) NAME: _____

Phone: _____

Address: _____

2) NAME: _____

Phone: _____

Address: _____

8. Brothers and Sisters:

Name	Age	Sex	School/Grade

9. Family Pets

10. List of persons other than parents to whom your child may be released:

11. Does your child have any allergies? If so, explain.

12. Does your child have any chronic health problems (asthma, diabetes, hyperactivity, bronchitis, etc.)

Type of treatment

Does your child require daily medication?

13. Does your child have any fears?

14. Has your child been away from you before''

15. How does your child frustrate or anger? (tears, tantrums, defiance, etc.)

16. Your child's word for urinating.

17. Your child's word for bowel movement.

18. Is your child sensitive to any foods? (If so, explain)

19. Food dislikes (please complete)

20. Is there any past experience concerning your child that you feel we should know about?

Parents Signature

Date _____

Interviewing Notes: