Name of Facility: Le Parasol

CHILD'S STARTING DATE: 18 / 09 / 04 (YY / MM / DD)

SEX: M X F ____

DATE OF BIRTH: 13 / 06 / 15 (YY / MM / DD)

NAME OF CHILD: Jalbout (Surname) Elan Henry (Given Names) ____ (Also Known As)

Name the Child responds to: Elan

Address: 3408 Weymoor Place, Vancouver, BC

Postal code: V5S 4G5 Phone: 604-733-6455

Person(s) with whom the child lives (adults and children): Heather (mother), Talid (father), Théo (brother), Charlotte (sister)

Child's first language: english Other languages: ____

Parent(s) / guardian(s):

Name: Heather Jalbout Home phone: none Cell phone: 604-733-6455

Work phone: none Days/hours of work: M-F, 9am-5pm E-mail: hakins@gmail.com

Name: Talid Jalbout Home phone: none Cell phone: 604-724-5513

Work phone: none Days/hours of work: M-F, 9am-5pm E-mail: tjalbout@gmail.com

Person(s) authorized to pick up the child and be contacted in case of emergency. These people should be available during hours of care. (include mother / father / guardian):

Name: Lisa & Gavin Chow Relationship to child: family friends

Home phone: 604-517-5177 Work phone: Lisa 604-524-5557 Cell phone: Gavin 604-454-8822

Name: Christine & Mark Schleppe Relationship to child: neighbours/friends

Home phone: none Work phone: Mark 604-836-8007 Cell phone: Christine 604-836-0587

Name: Andrea & Jamie Middleton Relationship to child: aunt & uncle

Home phone: 604-530-2203 Work phone: 778-549-7047 Cell phone: 778-549-8052

Name: Heather & Talid Jalbout Relationship to child: parents

Home phone: none Work phone: Heather 604-733-6455 Cell phone: Talid 604-724-5513

If appropriate, list an English speaking contact:

Name: all listed above Phone: ____

Has the child previously attended daycare/preschool?

YES ☒ NO ☐ Comments: ____

Comments/instructions to help us care for your child. (Please feel free to add additional pages.):

Toileting/Diapering (special words): ____

Rest Time (special comfort – toy/blanket): ____

Eating/Mealtime (include food likes/dislikes): ____

Fears: ____

Please tell us anything else you think will help us provide an enriching experience for your child: ______________________

____

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HEALTH INFORMATION

Health professionals involved with your child (other than doctor and dentist):

NAME	PROFESSION/AGENCY	
____________________	____________________	Phone: ______________
____________________	____________________	Phone: ______________
____________________	____________________	Phone: ______________

Does your child have:

A medical condition/concern? YES ☐ NO ☒
If yes, please provide further information: ______________________________

Allergies? YES ☐ NO ☒
If yes, please provide further information: ______________________________

Asthma? YES ☐ NO ☒
If yes, please provide further information: ______________________________

Has your child had a seizure in the past year? YES ☐ NO ☒
If yes, please provide further information: ______________________________

Does your child require a special diet related to a medical condition? YES ☐ NO ☒
If yes, please provide further information: ______________________________

Food sensitivities? YES ☐ NO ☒
If yes, please provide further information: ______________________________

List all prescription and "over the counter" medications your child receives:

Medication	Times Given	Reason for Medication
none		

You may be asked to complete additional forms if you answered yes to any of the above.

This health information may be made available to the staff of Vancouver Coastal Health.

Custody Agreement YES ☐ N/A ☒ **Provided to Facility** YES ☐ NO ☐ N/A ☐
Immunization Documents Returned to Facility YES ☐ NO ☐

Information Provided By: ____________________ ____________________
Print Name Signature

DATE: ________/______/______
YY MM DD

Information Received By: ____________________ ____________________
Print Name Signature

DATE: ________/______/______
YY MM DD

Office Use Only
Date Child Leaves the Facility: DATE: ________/______/______
YY MM DD