

PARENT AGREEMENT FORM (Drop in or Back up)

Select one: Drop In Back Up

Child: _____ Birth date: _____ Alberta Health Care # _____

Child: _____ Birth date: _____ Alberta Health Care # _____

Name of Educator doing drop in or back up care: _____

Name of child(ren)'s regular Educator (leave blank for drop in): _____

I agree to take my child(ren) to the dayhome at _____ and to pick up at _____
on these dates: _____

Drop in Care is defined as using a maximum of 4 days per month with the agency. Payment is made privately to the educator. If attending more than one dayhome, care cannot exceed 4 days total per month between the dayhomes.

Back up Care is defined as using 10 days or less in another dayhome with our agency. If you will not be attending back up care the following day, you must contact the dayhome educator or agency by 9pm the night before, otherwise you will still be charged for the full day. During business hours, please call 780-715-1166. For after-hours, an emergency contact number will be listed on our voicemail.

Parent/Guardian 1: _____ Cell #: _____
Address: _____ City: _____ Postal Code: _____
Email address: _____
Place of work/school: _____ Work #: _____
Work/School Address: _____

Home address same as above: Yes No

Parent/Guardian 2: _____ Cell #: _____
Address: _____ City: _____ Postal Code: _____
Email address: _____
Place of work/school: _____ Work #: _____
Work/School Address: _____

IN AN EMERGENCY (when neither parent can be reached), whom can we contact and has authorization to pick up the child? Please have at least one contact who resides in Edmonton or surrounding areas.

Name: _____ Cell#: _____ Work/Other #: _____
Address: _____ Relationship to Child: _____
Name: _____ Cell#: _____ Work/Other #: _____
Address: _____ Relationship to Child: _____

In the event of an emergency when I cannot be reached, I give my permission for medical procedures deemed necessary by a doctor or medical emergency team. I agree to compensate my Educator for the cost of any such medical assistance obtained.

Medical Information:

Medical Conditions: _____

Dietary Restrictions: _____

Prescribed Medications: _____

My child's immunizations are up to date: Yes No

Does your child have a potential life-threatening allergy? Yes No

Does your child require health care (additional to giving medication)? Yes No

If yes, provide details:

Please offer any information regarding custody or visitation agreements which may affect your child while in our care (Without a court order we do not have the ability to limit/deny access to a parent.)

Person(s) who do NOT have access to child _____
(if this person is the child's parent, you must provide the Court Order)

School: Not in school Attending Kindergarten Attending grade 1-6

School Name: _____

Notes (optional):

By signing below, I agree that the information on this document is correct to the best of my knowledge.

Parent Signature: _____ Date _____

Educator Signature: _____ Date _____