

**MANNING FAMILY DAY HOME PROGRAM**  
**DROP-IN CHILD CARE APPLICATION FORM**



Name of Child: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Alberta Health Care Number: \_\_\_\_\_ Childs Residence: Same as Mom  Same as Dad

Immunizations up to date  yes  no Allergies \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ Hm Ph \_\_\_\_\_ Wk Ph \_\_\_\_\_ Cell \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Street Address \_\_\_\_\_

Hours of Work: \_\_\_\_\_ Employer: \_\_\_\_\_ Ph # \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ Hm Ph \_\_\_\_\_ Wk Ph \_\_\_\_\_ Cell \_\_\_\_\_

Mailing Address:  same as above or \_\_\_\_\_

Street Address \_\_\_\_\_

Hours of Work: \_\_\_\_\_ Employer: \_\_\_\_\_ Ph # \_\_\_\_\_

Any special instructions regarding the care of the child, i.e.: medical, allergies, eating, sleeping, toileting schedules: \_\_\_\_\_

In the event of an emergency the parent/guardian can be reached at: \_\_\_\_\_

*In the event of an emergency where the Parent **cannot** be reached, the Parent hereby grants permission for medical treatment to be obtained from their family doctor, or any doctor selected by the Provider or Family Day Home Visitor.*

1. Emergency Contact Person: Name: \_\_\_\_\_  
(Other than parents-local) Home Address \_\_\_\_\_  
Hm ph: \_\_\_\_\_ Wk ph: \_\_\_\_\_ Cell \_\_\_\_\_  
Relationship: \_\_\_\_\_

2. To whom the Day Home Provider may release your child(ren): \_\_\_\_\_

3. Name of anyone **NOT** allowed access to child: \_\_\_\_\_

Fees for child care on a Drop-in basis are as follows:

8 hrs \$40.00 per day

**Fees:** Parents state the number of hours required, this includes the time they require to get to work in the morning and the time needed to get from work to the Provider's home, in the afternoon. **Late charges of \$5.00 per fifteen minutes, or portion thereof, will be charged by the Agency.**

*Payment is payable to the Manning Regional Family Day Home Program and is collected by the provider. A receipt will be issued upon request.*

**\*Note** - It is a requirement of the Agency that the Parent sign their child(ren) in and out on the Provider's Time Sheet.

Parent's Signature \_\_\_\_\_ Date: \_\_\_\_\_