East Preston Day Care and Family Resource Centre

Postnatal Registration

Personal Information

Name: Last:_____First: _____Middle:_____

Address: _____Postal Code: _____

Home Ph:_____Cell Ph: _____ Emerg. Ph:_____

Have you attended a postnatal group in the past: Yes No

If Yes please indicate which location: _____

_____

Transportation Required: Yes No

Address for pick up if different from above: _____

_____

Name of Emergency Contact:

_____

_____

Names of child/ren and birthdates of those attending program with you:

1._____

2._____

3._____

Medical Information

Health Card Number: _____ Expiry Date: _____

Health Card Number: _____ Expiry Date: _____

Health Card Number: _____ Expiry Date: _____

Health Card Number: _____ Expiry Date: _____

Family Doctor:_____ Phone#: _____

Known Allergies: _____

_____

Medications: _____

_____

Medical Conditions/Disabilities: _____

_____

Signature:_____ Date:_____