

ABORIGINAL MOTHER CENTRE SOCIETY DAYCARE APPLICATION

AMCS Fax Number: 604-558-2628

Email: daycare@aboriginalmothercentre.ca

Date: _____ Birth Date: _____ Gender: _____
Day Month Year Day Month Year M F

Name of Child: _____
(Last Name) (First Name) (Also known As)

Address: _____

City: _____ Postal Code: _____

Parent/Guardian: _____

Phone: _____ Cell: _____ Work: _____

Parent/ Guardian: _____

Phone: _____ Cell: _____ Work: _____

Email Address: _____

Preferred Start Date: _____ Child's Age at Application: _____

Day Month Year _____

Full Time: _____ Part-Time (3 days) _____ Part-time (2days) _____

Mon/Tues/Wed/Thurs./Fri Mon/Wed./Fri Tues/Thurs.

Does your child require any extra supports? Yes _____ No _____

If yes, please describe: _____

Signature of Parent/Legal Guardian _____ Date _____

Note: Acceptance of this Application implies no guarantee as to the availability of a space for your child. Future siblings require another application, if they wish to attend

AMCS Daycare Administration

Date Received: _____ Received By: _____