

MANITOBA EARLY LEARNING AND CHILD CARE DESIGN SUMMARY for PERMIT APPLICATION

This form must be completed by the license applicant in consultation with their Child Care Coordinator. This form must accompany the detailed floor plans which the applicant submits, first to their Child Care Coordinator for approval and signature. The signed form is submitted with building plans, in triplicate to the appropriate Authority having jurisdiction. This form is used to accompany building permit and/or occupancy permit submissions.

NAME OF CENTRE: _____	Located in a School? <input type="checkbox"/> Yes <input type="checkbox"/> No	
CENTRE CONTACT PERSON: _____	PHONE: _____	FAX: _____
ADDRESS: _____	P.C.: _____	EMAIL: _____
CHILD CARE COORDINATOR : _____	PHONE: _____	
EMAIL: _____	Relocation of existing site? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Complete the following: (check all that apply) Expansion of existing site? <input type="checkbox"/> Yes <input type="checkbox"/> No		
TYPE OF CENTRE:	TYPE OF CARE	CHILD OCCUPANTS:
<input type="checkbox"/> Full Time	<input type="checkbox"/> Infant (IN)	0 - 2 Years: _____ Infants (IN)
<input type="checkbox"/> Nursery School	<input type="checkbox"/> Preschool (PS)	2 - 6 Years: _____ Pre-school (PS/ K)
<input type="checkbox"/> School Age	<input type="checkbox"/> Kindergarten (K)	6 -12 Years: _____ School Age (SA/ K)
	<input type="checkbox"/> School Age (SA)	Total children: <input style="width: 50px;" type="text"/>

CHILD CARE AREA SUMMARY

Complete the following chart for each individual child care room. Indicate if measurements are in square feet (sq.ft) or square metres (sq.m). Attach floor plan for reference.

Type of care (IN /PS /K /SA)	Room #	Play area Sq. ft/ Sq. m	Natural light Sq. ft / Sq. m	Nap area Sq. ft/ Sq. m	Number of toilets/ urinals	Number of hand basins	Licensed Spaces/ room D = Dedicated S = Shared use

Final licensed numbers will be verified by site measurement at construction completion.

FOR OFFICE USE ONLY

SITE MEASUREMENTS VERIFIED: Yes No Date: _____ Initial: _____ Initial: _____

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<u>FOOD SERVICE:</u>	Full Meals <input type="checkbox"/>	Snacks Only <input type="checkbox"/>	
	Yes No	Yes No	Yes No
<u>STOVE:</u>	Domestic <input type="checkbox"/> <input type="checkbox"/>	Commercial <input type="checkbox"/> <input type="checkbox"/>	Exhaust Canopy <input type="checkbox"/> <input type="checkbox"/>
<u>REFRIGERATION:</u>	Domestic <input type="checkbox"/> <input type="checkbox"/>	Commercial <input type="checkbox"/> <input type="checkbox"/>	Freezer <input type="checkbox"/> <input type="checkbox"/>
<u>DISHWASHER:</u>	Domestic <input type="checkbox"/> <input type="checkbox"/>	Commercial <input type="checkbox"/> <input type="checkbox"/>	Hot Water Booster <input type="checkbox"/> <input type="checkbox"/>
	Separate Hot Water Tank <input type="checkbox"/> <input type="checkbox"/>		Chemical Sanitizer <input type="checkbox"/> <input type="checkbox"/>
<u>FINISHES:</u> Cabinets & Counter tops: _____ Walls: _____ Ceilings: _____			
Yes No	Yes No	Yes No	Yes No
Hand basin <input type="checkbox"/> <input type="checkbox"/>	3 Compartment Sink <input type="checkbox"/> <input type="checkbox"/>	Drain Board <input type="checkbox"/> <input type="checkbox"/>	Flooring Covered 4 inches <input type="checkbox"/> <input type="checkbox"/>
Yes No			
Locked Storage For Hazardous Chemicals: <input type="checkbox"/> <input type="checkbox"/>			

OUTDOOR SPACE

Onsite Outdoor Play Space: _____ sq.ft./ sq m.
 Offsite designated Green space: _____
 Walking Distance: _____

Drop Off/Pick Up Yes No

Near Entrance:

Staff parking:

parking stalls: _____

drop off spots: _____

BASEMENT OCCUPANCY

Proposed: Yes No

Ceiling Height: _____

Backflow Prevention: Device: _____
 Type: _____

SEWAGE SYSTEM: Type of System: _____

VENTILATION AND EXHAUST

Method of Heating and Ventilation:

Central Air Conditioning Electric
 Hot Water Forced Air Other

Air quality: Yes No

Minimum 15 cubic feet per minute per person
 Operable windows present

Washroom Ventilation:

Mechanical Window Other

FIRE PROTECTION Yes No

Fire Alarm: Smoke Zones:
 Sprinklers:

LIGHTING Yes No

Light bulbs are shielded
 Type of protection: _____

PLANS APPROVED BY:	FOR OFFICE USE ONLY	
CHILD CARE COORDINATOR: _____		Date: _____
PUBLIC HEALTH: _____		Date: _____