AFTER SCHOOL PROGRAM STUDENT REGISTRATION FORM

Child's name _____ F____ M____ Birthdate:_____

Address _____ Telephone No. _____

City _____ Postal Code _____

Email Address_____

Mother's name _____Cellphone No. _____

Place of business _____Telephone No. _____

Address _____

Father's name _____Cellphone No. _____

Place of business _____Telephone No. _____

Address _____

Please name two people that could be called in an emergency, if parents cannot be reached

1st name _____Telephone No._____

Relationship _____Address_____

2nd name _____ Telephone No. _____

Relationship _____Address_____

Where does your child currently attend school?_____

_____

_____

_____

_____

2191 Van Horne Drive Kamloops, B.C. V1S 1L9
(250)372-9940

Would you tell us a little about your child?

a) Physical abilities, interests _____

b) Personality characteristics – shy, outgoing, any fears? _____

c) Is there anything else you can think of that would help us to know and understand your child better?

Other children in the family?

Name	Age	Sex M/F

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AUTHORIZATION FORM

Child`s Name: _____

Pick-up and Transportation

Other than the signing parent, **only** the following persons have the authorization to pick-up and transport my child:

1. _____
2. _____
3. _____
4. _____
5. _____

Is there any person not permitted to access your child? Yes _____ No _____

Name of the person: _____

Relationship to the child: _____

Field Trips

I give permission for my child to take part in "walking field trips" near the school, whether preplanned or spontaneous. I understand that I will be notified of all Field Trips that require transportation. I understand that I will be responsible for transporting my child to and from field trip locations away from the school and in so doing, give permission for my child to attend.

_____

Signature of Parent or Guardian

In case of illness or medical emergency, I understand the following:

- I cannot send my child to school when he/she is ill.
- I give the staff permission to call a doctor or ambulance in case of emergency.
- No medication will be given without the written consent of child's parent or guardian.
- Medication is to be provided in the original labeled container.
- When giving prescribed medication, the date, time and amount of medication will be recorded and initialled.
- If my child becomes sick at school, I agree to have her/him picked up as soon as possible

_____

Signature of Parent or Guardian

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HEALTH FORM

To be completed and returned with your child upon commencement of the school year in September.

Child:_____ Sex:____ Birthdate:_____

Home Phone Number:_____ Address:_____

Father's Name:_____

Business Phone:_____ Cellphone Number:_____

Mother's Name:_____

Business Phone:_____ Cellphone Number:_____

Doctor's Name:_____ Phone Number:_____

Care Card Number:_____ IMMUNIZATION: YES_____ NO_____

Emergency Contact Persons (other than parents)

Name	Address	Phone Number
Name	Address	Phone Number

1. General State of Health_____
2. Any allergies?_____

   Is the child subject to **Yes** or **No**

   Colds_____ Bronchitis_____ Sore throats_____ Urine infection_____ Hay fever_____

   Bleeding nose_____ Ear infection_____ Convulsions_____ Skin conditions_____ Asthma_____
3. Is your child on any medication?_____
4. Is your child on any diet restrictions? (If different from allergies)_____

   _____
5. Any Physical/Learning concerns?_____
6. Any vision, hearing or speech concerns?_____

   _____
7. Any social/behavioral/emotional concerns?_____

   _____
8. Is child independent at using the toilet?_____
9. Does your child have any particular fears such as loud noises, costumes, uniformed people, and dogs?

   _____
10. Other medical problems?_____

MEDICAL ALERT FORM

For School Year: _____

Student Name: _____ Birth Date: _____

Parent or Guardian: _____ Home Phone: _____ Bus Ph: _____

Emergency Contact Name: _____ Home Phone: _____

Physician: _____ Phone: _____

Potentially life threatening medical condition diagnosed as: _____

1. New Condition: ☐ Yes ☐ No Date condition identified: _____
2. Describe the potential problem: _____

_____

_____

PLAN WHILE IN THE CARE OF THE SCHOOL:
To be updated annually and when the child's condition changes. The plan is updated by the student/parent, in consultation with the family physician and reviewed with appropriate school staff and when necessary, Community Care Facilities Licensing.

- Symptoms to watch for are: _____

  _____

  _____

- Precautions in the classroom are: _____

  _____

  _____

Medication needed: ☐ Yes ☐ No Name of medication: _____

(If yes "Request for Administration of Medication at School" form Parts A, B, & C must be completed and provided to the school)

***Emergency Plan** school staff need to follow (step by step):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

INFORMATION REVIEW by parent/guardian:
(Review minimum annually) sign & date

1. _____
2. _____
3. _____

TRAINING REVIEW:
(Review minimum annually) sign & date

1. _____
2. _____
3. _____

KAMLOOPS CHILDCARE

ABERDEEN HILLS MONTESSORI
PRESCHOOL/KINDERGARTEN
2191 Van Horne Drive
Kamloops, B.C. V1S 1L9
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CHILD RELEASE FORM

Child's Name: _____

I understand that the school staff will not release my child to any authorized individual if they are intoxicated or displaying any erratic behaviour , making them unable to adequately care for my child and potentially jeopardizing their health and safety.

Parent/guardian signature: _____

Date: _____

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PHOTOGRAPH PERMISSION FORM

Please note: Our school requires a photograph of your child for our records, prior to their enrolment.

I give permission for my child, _____, to be photographed. I understand that these photographs will be used for my child's records and may be used for classroom displays, projects, school website and the school's official social networking page.

Parent/guardian Signature: _____

Date: _____

CARDS

It is strongly recommended that when staff leave the facility premises with children, they carry abbreviated records for each child along with the required portable first aid kit. These records provide essential information and consents to access emergency medical treatment.

(Side 1)

EMERGENCY CONSENT CARD

Name: _____ Sex: M F

Birthdate: _____

Address: _____

Home Phone: _____

Guardians
Name: _____

Work Phone: _____

Name: _____

Work Phone: _____

Alternate Contact:

Name: _____

Phone: _____

Child's Dr.: _____

Phone: _____

Most recent Tetanus shot: _____

MMR: _____

Allergies/Medications: _____

Child's Dentist: _____

Phone: _____

CONSENT FORM

(Side 2)

Child's Name: _____

Medical #: _____

It is the facility's policy to notify the parent when a child is ill or requires medical attention. If we are unable to contact the parent and the child need immediate medical help, parental consent is necessary for facility staff to take appropriate action on behalf of the child. Your consent will accompany the child to the emergency centre.

I authorize the staff at the _____ child care facility to call a physician, take my child to the nearest emergency centre or summon an ambulance for emergency medical aid should the person(s) in attendance feel such services are required and I cannot be contacted by phone. If such emergency should arise, I shall be notified as soon as possible. I agree that any cost incurred for such services shall be the sole responsibility of myself.

Date: _____

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Signature: _____

Alternate Identification:
Child's name_____
Height_____
Weight_____
Eye Color _____
Hair Color_____