St. Thomas the Apostle Nursery School

Registration Booklet

CHILD'S NAME: _____

For office use only

Program options: _____

Date of Admission:_____Discharge: _____

☐ January	☐ February	☐ March	☐ April	☐ May	☐ June
☐ July	☐ August	☐ September	☐ October	☐ November	☐ December

- ☐ **Registration fee paid**
- ☐ **Parent ID**
- ☐ **Child Immunization**
- ☐ **Emergency Contacts**
- ☐ **Input to HiMama**

2345 Alta Vista Drive, Ottawa, ON K1H 7M6
www.stthomastheapostlenurseryschool.ca
email: director@stthomastheapostlenurseryschool.ca
Phone: 613-731-4150

REGISTRATION

PERSONAL INFORMATION		
Child's Name Last Name:	First Name:	Gender: Male ☐ Female ☐
Address Street:	City:	Postal Code:
Birth Date: ____/____/____ (dd/mmm/yyyy)		
Parent / Guardian Last Name:	First Name:	Gender: Male ☐ Female ☐
Address: Street:	City:	Postal Code:
Home #:	Cell #:	Work / School #:
e-mail address:	Place of Employment / Education: Occupation: Address:	
Parent / Guardian Last Name:	First Name:	Gender: Male ☐ Female ☐
Address: Street:	City:	Postal Code:
Home #:	Cell #:	Work / School #:
e-mail address:	Place of Employment / Education: Occupation: Address:	
Custody Information Child lives with:	Relationship to child:	
Do both parents have access to the child at the Child Care Centre?		
If no, is there a legal document in effect?		Copy on file?

Please list other members of the household:

Name	Relationship to child	Children's date of birth

PROGRAM INFORMATION

Please indicate the program options you'd like:

PRESCHOOL PROGRAM Mornings: [9:00 – 11:30 am]	PRESCHOOL PROGRAM Afternoons: [1:00 – 3:30 pm]	TODDLER PROGRAM Mornings: [9:00 – 11:30 am]	LUNCHTIME [11:30 –12:30]
☐ Mon/Wed/Fri ☐ Tues/Thurs ☐ Mon to Fri	☐ Mon/Wed/Friday Bilingual ☐ Tues/Thurs Bilingual ☐ Mon to Fri 1:00-3:30	☐ Mon/Wed /Fri ☐ Tues/Thurs ☐ Mon to Fri	☐ Mon/Wed/Fri ☐ Tues/Thurs

☐ INFANT Full day (7:30-5:30)
☐ TODDLER Full day (7:30-5:30pm)
☐ Preschool Full day (7:30-5:30 pm)
☐ Kindergarten year long (7:30-5:30 pm) AM/PM or AM only or PM only (please circle)
☐ School age year long (7:30-5:30 pm) AM/PM or AM only or PM only (please circle)
☐ Kindergarten or SA summer program _____

Emergency Contact (if Parent(s) or Guardian(s) cannot be reached)

EMERGENCY INFORMATION

Name:	Relationship to child:	
Address:	City:	Postal Code:
Home #:	Cell #:	Work / School #:
Name:	Relationship to child:	
Address:	City:	Postal Code:
Home #:	Cell #:	Work / School #:

MEDICAL/HEALTH INFORMATION

Child's Physician:	Phone #:	
Address: Street:	City:	Postal Code:
Child's Health Card # (optional):		Please specify:

Permission for Emergency Medical Attention

Should an accident or illness occur when your child is in our care, medical attention may be necessary. Should this situation arise, we need prior permission to have your child transported from the program to seek medical attention. We will make every attempt to contact you before removing your child or as soon as possible thereafter.

I hereby authorize the childcare centre to have my child transported from the Centre to seek medical attention in the case of an emergency.

Parent / Guardian Name:	Date:
Signature:	

MEDICAL/HEALTH INFORMATION CONTINUED

Does your child have any health conditions that might require emergency action while attending the Centre (i.e. anaphylactic allergies, seizures, diabetes, asthma, bleeding disorders)? Please specify.

Is your child on a continuing prescribed medication? Please specify.

Does your child have any food allergies or food restrictions (Vegetarian, no prok etc.) or a special food diet? Please specify.

Does your child have any physical or learning difficulties (i.e. autism, language delay, ADHD)? Please specify.

Does your child have any conditions relating to:

Allergies	☐ Yes / No ☐	Heart	☐ Yes / No ☐
Asthma	☐ Yes / No ☐	Hemophilia	☐ Yes / No ☐
Bone, Joint	☐ Yes / No ☐	Kidney, Bladder	☐ Yes / No ☐
Convulsions	☐ Yes / No ☐	Muscular Co-ordination	☐ Yes / No ☐
Diabetes	☐ Yes / No ☐	Rheumatic Fever	☐ Yes / No ☐
Eczema	☐ Yes / No ☐	Speech	☐ Yes / No ☐
Epilepsy	☐ Yes / No ☐	Tuberculosis	☐ Yes / No ☐
Hearing	☐ Yes / No ☐	Vision	☐ Yes / No ☐
Other:			

Has your child had any of the following diseases?

Chicken Pox	☐ Yes / No ☐	Polio	☐ Yes / No ☐
Diphtheria	☐ Yes / No ☐	Tetanus	☐ Yes / No ☐
German Measles	☐ Yes / No ☐	Whooping cough	☐ Yes / No ☐
Mumps	☐ Yes / No ☐		

Please add any other information about your child's health or behaviour that you feel may be of importance (particular fears, rest habits, toileting habits, etc.).

Note any agencies that are currently working with the family (Children's Aid Society, Public Health Nurse, Children's Integration Support Services, etc.).

PERMISSION / CONSENT INFORMATION

Permission for Child Release

Please list the person(s) to whom your child may be released. (Please include the 2 emergency contacts)

Name	Home/Cell Number:	Work Number:	Relationship to Child

Note any further instructions:

Please Note: According to the law, both parents have equal access to their child and to the information about the child's development, health and welfare. The only time the Director or staff can deny access of a parent to a child is when there is a written separation agreement or a legal court order. A copy of this document is required for the Centre.

The Director and staff will not release a child to a person if there is reason to believe the child is in any danger. Children will not be released to a person who is under 16 years of age. In addition, the Centre is not permitted to release your child to any person without authorization. All permanent changes in permission of release must be made in writing.

Parent / Guardian Name:	Date:

Signature:

Permission for Communication between the Child Care Centre

I give my consent for the childcare centre to have ongoing communication with my child's resource teachers etc regarding information which relates to the physical, emotional and social development of my child.

Parent / Guardian Name:	Date:

Signature:

PERMISSION / CONSENT INFORMATION CONTINUED

Walking trip permissions:

I give my permission to the child care centre to take my child on walking trips within a 2 km distance from the Centre.

Parent / Guardian Name:	Date:
Signature:	

Permission for photographs to be used on website and Facebook:

I give my permission to the child care centre staff to post photos for advertising purposes on the nursery school website: YES or NO ☐ ☐ Facebook: YES or NO ☐ ☐

Parent / Guardian Name:	Date:
Signature:	

Permission to Take Photographs

The Centre may wish to take photographs of the children at various times throughout the year. Some of the slides or photographs will be used for classroom display, individual portfolios and group posts on HiMama. Before we can use your child's photograph, we require written permission.	YES / NO ☐ ☐

Parent / Guardian Name:	Date:
Signature:	

Parent Handbook Acknowledgement Form

The following signature acknowledges that I have read the **Parent Handbook** located on our website at **www.stthomastheapostlenurseryschool.ca** I understand and agree with the Centre's policies as outlined in the handbook.

Parent / Guardian Name:	Date:
Signature:	

Nutrition Policy

We have a legislated obligation to develop a policy on children's nutrition that is consistent with the Ministry's guidelines. STTANS provides morning snack, lunch and afternoon snack to our toddler and preschool programs. STTANS provides afternoon snack for our kinder/school age programs. All infants must bring lunches from home and should include a variety of foods from the following chart:

Food Groups	**Amount Offered (attendance 6 hours per day)**
milk and milk products	250 – 375 mls
meat and alternatives	60 – 90 mls
breads and cereals	450 mls or 2 ½ slices
fruit and vegetables	300 mls or 2 ½ whole fruit

All infant children bring their own bagged lunches from home. These should include morning snacks, lunch, afternoon snacks and milk or formula. The combination of Infant snacks and noon-time meals should be equivalent to the guidelines set out in the chart above. Staff are expected to be vigilant regarding the content of infant bag lunches and advise parents when there are concerns regarding the nutritional adequacy of the lunches. Please also pack lunches according to the policy of the Centre (i.e. peanut / nut restricted products)

The Centre will routinely provide nutritious morning, afternoon snacks & lunch for our full-day preschool and toddler programs. The menu will consist of dairy products such as milk, cheese, yogurt, whole grain crackers, a variety of fresh fruit, vegetables, protein etc.

Child's name:	Date:
Parent's name and Signature:	

PARENT PARTICIPATION INFORMATION

It is especially important to our Centre to have a group of parent volunteers for our Board of Directors. Would you be interested in serving on the Board of Directors?	YES / NO ☐ ☐

The following is a list of areas in which you could be very helpful in assisting our Centre in maintaining its smooth and successful operation. Please indicate your areas of interest.

- ☐ computer consultant to staff and children
- ☐ sharing your expertise (i.e. lawyer, accountant, etc.) Please specify _____
- ☐ planning special events for fundraising
- ☐ sharing your hobby (knitting, sewing, painting, etc.)

Comments or suggestions: _____

_____

_____

NOTES

St. Thomas the Apostle Nursery School
Child INFORMATION SHEET

The information you give us on this sheet will help us in responding to your child's needs. It will only be used by the staff.

1. How did you hear about our program? (ie. the sign in front of the school, newspaper ad, website, friend or neighbor)

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2. Child's full name.

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3. Are there any other children or relatives in your home? Please give names, ages, and relationship to your child.

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4. Does your child have other playmates and/or pets?

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5. Has your child previously taken part in group activities such as play group, nursery school or daycare?

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6. Please describe any behavior difficulties your child might have. (ie. biting, fears, finger sucking, tantrums etc.)

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7. Please describe your child's language development. (Languages spoken at home and general ability)

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8. What are your child's interests?

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9. What would you like to see your child accomplish at school?

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10. Are there circumstances you feel we should know about, to help us better understand your child? (ie. premature birth, adoption, death, single parent, divorce, recent move, new baby etc.)

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11. Does your child have any medical concerns we should know about? (ie. contagious diseases, epileptic seizures, heavy nose bleeds etc.)

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12. Does your child have any problem with toileting? (Please explain)

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St. Thomas the Apostle Nursery School EMERGENCY FORM

Child's Last Name:		**Date of Birth:** ____/____/____(dd/mmm/yyyy)	
Child's First Name:		**Gender:** **Male** ☐ **Female** ☐	
Physician's Name:		**Physician's Telephone Number:**	
Physician Address:		**Health Card Number (optional):**	
Allergies / Restrictions:			
Parent / Guardian Last Name:		**Gender: Male** ☐ **Female** ☐	
First Name:		**Work name and address:**	
Cell Number:	**Home Number:**	**Work Number:**	
Home Address:		**City:**	**Postal Code:**
Parent / Guardian Last Name:		**Gender: Male** ☐ **Female** ☐	
First Name:		**Work name and address:**	
Cell Number:	**Home Number:**	**Work Number:**	
Home Address:		**City:**	**Postal Code:**

Emergency Contact (if Parent(s) or Guardian(s) cannot be reached)			
Name:		**Name:**	
Cell/Home Number:	**Work Number:**	**Cell/Home Number:**	**Work Number:**
Relationship:		**Relationship:**	

AUTHORIZED FOR CHILD RELEASE		
Adult's Name:	**Home/Cell Number:**	**Work Number:**

PARENTAL PERMISSION FOR EMERGENCY TREATMENT

I give my permission that in case of an emergency, if I am not immediately available, the physician on duty may hospitalize and secure proper treatment for ordering injection, anesthetics or surgery for my child. I also give my permission for my child to be transported to the emergency department of the nearest hospital with **no** liability on the driver's part.

Print name of Parent / Guardian:	**Signature of Parent / Guardian:**	**Date:**

Office use Only	**Sibling(s):**	**Admission Date:** ____/____/____(dd/mm/yy)	**Discharge Date:** ____/____/____(dd/mm/yy)

St. Thomas the Apostle Nursery School
2345 Alta Vista Drive, Ottawa, ON K1H7M6 613-731-4150

Consent to Receive Electronic Communication Form

Guidelines

It is the belief of St. Thomas the Apostle Nursery School that keeping our prospects, clients, and customers informed of company news and services plays a significant role in our ability to provide exceptional service to our clientele. In accordance with Canada's Anti-Spam Law (CASL), St. Thomas the Apostle Nursery School seeks the express consent of all prospects, clients, and customers prior to the distribution of any commercial electronic messages.

Consent

□ I agree to receive the following commercial electronic messages from St. Thomas the Apostle Nursery School (please check all that apply):

☐ *New offers and promotions*

☐ *daily reports via our centers Online portfolio site (HiMama/Storypark etc)*

☐ *Monthly newsletter*

☐ *St. Thomas the Apostle Nursery School news and announcements*

☐ *I do not agree to receive commercial electronic messages from St. Thomas the Apostle Nursery School.*

I,_, have read and understood the above information about receiving commercial electronic messages and hereby give my voluntary permission to St. Thomas the Apostle Nursery School to send me commercial electronic messages in accordance with my above selections. I understand that I may withdraw my consent at any time by notifying St. Thomas the Apostle Nursery School at 613-731-4150 or by unsubscribing to any future commercial electronic messages I receive from St. Thomas the Apostle Nursery School. I understand that the information collected here will be used only for the purpose as indicated above.

Name: _____

Email: _____

Signature: _____

Date:

Authorization for Release of Information

*Child's name:*_____ *Date of Birth*_____

*I,*_____ *authorize the release of information completed on the above named child, to be shared.*

If one or more service (check below) is able to provide information, please photocopy and submit to our childcare.

Ottawa Children's Treatment Centre (OCTC)

- ☐ *Getting Started/Wee start Consultation Report*
- ☐ *Blind/Low vision Assessment*
- ☐ *Occupational Therapy Assessment*
- ☐ *Physiotherapy Assessment*
- ☐ *Speech-Language Pathologist Assessment*
- ☐ *Psychological/Developmental Assessment*

Children's Hospital of Eastern Ontario (CHEO)

- ☐ *Speech-Language Pathologist Assessment*
- ☐ *Physiotherapy Assessment*
- ☐ *Audiology Assessment*
- ☐ *Genetic Assessment*
- ☐ *Occupational Therapy Assessment*
- ☐ *Psychological/Developmental Assessment*
- ☐ *Neurology Assessment*

- ☐ *Ottawa Carleton Headstart Association for Preschools (OCHAP) Speech and Language*
- ☐ *Canadian National Institute for the Blind (CNIB)*
- ☐ *Other, Specify (name, complete address, phone number)*

_____

_____

*Signature of parent/guardian*_____

Date: _____