



REGISTRATION FORM 2016/17

STUDENT'S NAME:

_____ Last Name / Given Name / Middle Name

Name child responds to: _____ Sex: M F

Child's Starting Date: _____ Birth Date: _____
Date / Month / Year Date / Month / Year

Address: _____
Number / Street / City

Postal Code: _____ Home Phone: _____ Cell: _____

Child's First Language: _____ Second Language: _____

Please indicate the class session you prefer for your child:

- Morning Class (8:45–11:45 am) Afternoon Class (1:00–3:45 pm) Ex. Day Class (8:45 am –3:45 pm)

PARENT / GUARDIANS

Female: _____ Occupation: _____
(Mother)

Residence: _____ Home Phone: _____
Number / Street / City / Postal Code

Business: _____ Hrs. at Work: _____
Name of Company / Address

Wk. Phone: _____ Cell: _____ Fax: _____ Email: _____

Male: _____ Occupation: _____
(Father)

Residence: _____ Home Phone: _____
Number / Street / City / Postal Code

Business: _____ Hrs. at Work: _____
Name of Company / Address

Wk. Phone: _____ Cell: _____ Fax: _____ Email: _____

ALTERNATIVE PERSON(S) TO CALL IN CASE OF AN EMERGENCY:

_____ Name Relationship

_____ Address Phone Speaks English?

Name	Relationship
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Address	Phone	Speaks English?
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Name	Relationship
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Address	Phone	Speaks English?
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OUT OF PROVINCE CONTACT PERSON (Note: this individual would be contacted if there was no local telephone service due to a natural disaster):

Name	Relationship	Home Phone	Work Phone	Cellular
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PERSON(S) AUTHORIZED TO PICK UP CHILD (include mother and father):

Name	Relationship	Home Phone	Work Phone	Cellular
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Name	Relationship	Home Phone	Work Phone	Cellular
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Name	Relationship	Home Phone	Work Phone	Cellular
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Name	Relationship	Home Phone	Work Phone	Cellular
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SOCIAL INFORMATION:

Previous School/Daycare Attended: _____

Names and ages of siblings: _____

EMERGENCY HEALTH INFORMATION:

Doctor	Address	Phone
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Dentist	Address	Phone
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MEDICAL INSURANCE NUMBER: _____

If your child has had any allergies, significant illnesses or has had any operations or accidents, please indicate below:

For Office Use Only	<input type="checkbox"/> Rec'd.	<input type="checkbox"/> Reg.	<input type="checkbox"/> Dep.	Class	<input type="checkbox"/> AM	<input type="checkbox"/> EX
<input type="checkbox"/> Observation	<input type="checkbox"/> Interview	<input type="checkbox"/> Enrolled	Start Date: _____	<input type="checkbox"/> PM		