Rutland Community School **Tel: 250-765-4052**

620 Webster Road
Kelowna, BC
V1X 4V5

email: deborah.hughes@sd23.bc.ca

REGISTRATION FORM

General Information

Child Name _____
First Name Last Name Middle Name

Nick Name _____ Weight _____ Height _____

Sex (circle) M F Date of Birth _____ School _____
mm/dd/yyyy Name Grade

Special Needs and Subsidy Information

Subsidy Number _____ Subsidy Start Date _____ Subsidy Expiry Date _____
mm/dd/yyyy mm/dd/yyyy

Restrictions _____

Program

Program (circle) Grade 3-5 Kindergarden Grade 1/Grade 2

Facility Start Date _____
mm/dd/yyyy

Contacts (Parent/Guardian)

Contact Name _____
First Name Last Name

Address _____
Street City Prov. Postal Code

Home Telephone _____ Comments _____

Work Telephone _____ Comments _____

Alternate Telephone _____ Comments _____

Alternate Telephone _____ Comments _____

E-mail _____

Occupation _____ Employer Name _____

Employer Address _____
Street City Prov. Postal Code

Days & Hours Worked _____

Relationship _____ Primary Caregiver(circle) YES NO

Circle all relevant Emergency Contact Lives With Pick Up Authority Restraining Order

Comment

Contacts (Parent/Guardian)

Contact Name _____

First Name Last Name

Address _____

Street City Prov. Postal Code

Home Telephone _____ Comments _____

Work Telephone _____ Comments _____

Alternate Telephone _____ Comments _____

Alternate Telephone _____ Comments _____

E-mail _____

Occupation _____ Employer Name _____

Employer Address _____

Street City Prov. Postal Code

Days & Hours Worked _____

Relationship _____ Primary Caregiver(circle) YES NO

Circle all relevant Emergency Contact Lives With Pick Up Authority Restraining Order

Comment

Other Contact

Contact Name _____

First Name Last Name

Address _____

Street City Prov. Postal Code

Home Telephone _____ Comments _____

Work Telephone _____ Comments _____

Alternate Telephone _____ Comments _____

Alternate Telephone _____ Comments _____

E-mail _____

Occupation _____ Employer Name _____

Employer Address _____

Street City Prov. Postal Code

Days & Hours Worked _____

Relationship _____ Primary Caregiver(circle) YES NO

Circle all relevant Emergency Contact Lives With Pick Up Authority Restraining Order

Comment

Other Contact

Contact Name _____
First Name Last Name

Address _____
Street City Prov. Postal Code

Home Telephone _____ Comments _____

Work Telephone _____ Comments _____

Alternate Telephone _____ Comments _____

Alternate Telephone _____ Comments _____

E-mail _____

Occupation _____ Employer Name _____

Employer Address _____
Street City Prov. Postal Code

Days & Hours Worked _____

Relationship _____ Primary Caregiver(circle) YES NO

Circle all relevant Emergency Contact Lives With Pick Up Authority Restraining Order

Comment

Siblings

Sibling Name _____
First Name Last Name Program

Sibling Name _____
First Name Last Name Program

Sibling Name _____
First Name Last Name Program

Health & Medical Information

Health No. _____ PHN No. _____ Health Plan No. _____

Allergies/Medical Conditions _____

Diagnosis Agency _____ Date of Diagnosis _____ Agency Involved(circle) YES NO
mm/dd/yyyy

Special Needs Diagnosis _____

_____

Tested for Senses (circle) YES NO Required Treatment _____

Treatment Details _____

Other Information _____

_____

Family Physician

Physician Name _____

title First Name Last Name

Agency Name _____ Position _____ Field of Expertise _____

Address _____

Street City Prov. Postal Code

Home Telephone _____

Work Telephone _____

Alternate Telephone _____

Fax _____

E-mail _____

Comment _____

Other Consultant, Physician, Therapist, Dentist

Physician Name _____

title First Name Last Name

Agency Name _____ Position _____ Field of Expertise _____

Address _____

Street City Prov. Postal Code

Home Telephone _____

Work Telephone _____

Alternate Telephone _____

Fax _____

E-mail _____

Comment _____

Enter Schedule, if child is to attend more then one time per day use additional lines

Arrival Time _____ Departure Time _____ Days (circle) S M T W TH F S

Arrival Time _____ Departure Time _____ Days (circle) S M T W TH F S

Arrival Time _____ Departure Time _____ Days (circle) S M T W TH F S

Additional Information _____

Annual Update

I will initial registration forms annually to ensure information is current.

K_____Gr. 1_____ Gr. 2_____ Gr. 3_____

Gr. 4_____ Gr. 5_____

Starting Year:_____

Date _____ Mother/Guardian Signature _____

Date _____ Father/Guardian Signature _____

Emergency

In case of an emergency where my child(ren) require(s) medical attention, I give permission for the RCS staff to call an ambulance. I acknowledge that it is my responsibility to pay for ambulance/medical fees. I understand that my child may be released to a medical team and that staff may/may not be able to attend with child. I give permission for my child, in the case of emergency, to receive medical procedures deemed necessary by my physician or any other physician selected by the Facility. I understand that this will only happen after all attempts have been made to contact the parents and/or guardians, as listed in the registration forms at the Facility.

Date _____ Mother/Guardian Signature _____

Date _____ Father/Guardian Signature _____

Field Trips

I give permission for my child to accompany the Facility on field trips. I understand that this includes excursions on foot, with staff vehicles or on public transportation. (ie. local parks/playgrounds; 7-11 stores; fire hall etc.).

Date _____ Mother/Guardian Signature _____

Date _____ Father/Guardian Signature _____

Insect Repellent

I hereby authorize the Facility to apply insect repellent on my child during the season when children are at risk of insect bites. I am aware that the Facility will post signs notifying me of this action in advance of the season.

Date _____ Mother/Guardian Signature _____

Date _____ Father/Guardian Signature _____

Media

I give permission for members of the media, at the discretion of the director of the Facility, to take pictures/video of my child.

Date _____ Mother/Guardian Signature _____

Date _____ Father/Guardian Signature _____

Medicine

I will make every attempt to administer medication to my child at home. In the event that the medication needs to be administered during Facility hours, the following conditions will be respected: The medicine will be prescribed by a medical doctor, will be provided to a staff member in the original container with a legible prescription indicating the date, doctor's name, dosage and instructions. I will sign a further, more detailed medicine consent form at that time.

Date _____ Mother/Guardian Signature _____

Date _____ Father/Guardian Signature _____

Photos

I give permission for the Facility's staff to take pictures/videos of my child(ren) for Facility use only.

Date _____ Mother/Guardian Signature _____

Date _____ Father/Guardian Signature _____

Practicum

I give permission for my child to be observed by students in fields relevant to the field of child care if these observations are kept in confidence and used only as a means to fulfill their course requirements. These obsevations must be approved by the Facility. Students and volunteers must have a criminal record check and are always supervised by the staff.

Date _____ Mother/Guardian Signature _____

Date _____ Father/Guardian Signature _____

Privacy Policy

We hereby request your consent to disclose the collected information to Vari Tech Systems Inc. for the purpose of managing the software childcarepro on behalf of The Facility and in accordance with the Vari Tech Privacy Code. I understand that Vari Tech Systems Inc. will not disclose such personal information without my further consent unless required or permited by law. For additional information about the Vari Tech Privacy Code, please visit www.varitechsystems.com or contact the Vari Tech Privacy Officer at 204-231-7068 or by email at admin@childcarepro.ca.

Date _____ Mother/Guardian Signature _____

Date _____ Father/Guardian Signature _____

Release of Information

I authorize the release of any information or records requested to the staff of the Facility. This information will generally be requested from the program the child is transfering from or other professionals that are or have been involved with the child.

Date _____ Mother/Guardian Signature _____

Date _____ Father/Guardian Signature _____

Sunscreen

I hereby authorize the Facility to apply SUNSCREEN SPF 30+ on my child during the season when children are at risk of the sun. I am aware that the Facility will post signs notifying me of this action in advance of the season.

Date _____ Mother/Guardian Signature _____

Date _____ Father/Guardian Signature _____

Walk In Clinic of Choice

If we do not have family physician listed on the registration forms, our preference for walk in clinic is_____

Address_____

Phone #_____

Date _____ Mother/Guardian Signature _____

Date _____ Father/Guardian Signature _____

Withdrawal

I am aware that I must provide the Facility with one (1) months written notice before withdrawing my child. I am responsible for regular charges during the month of cancellation unless the Facility is able to fill the space immediately. If termination occurs during the last two months of the school year, I am responsible for charges for both months due to the difficulties in filling spaces late in the school year.

Date _____ Mother/Guardian Signature _____

Date _____ Father/Guardian Signature _____

Immunizations			
No Immunizations:		Immunization records attached:	
Immunization	Date	Immunization	Date
2 mth DPTP		2 mth Hepatitis B	