

For Registrar use only please:

CHILD'S NAME: \_\_\_\_\_ CLASS: \_\_\_\_\_

Enrolment Date: \_\_\_\_\_

End Date: \_\_\_\_\_

Please indicate which program you are enrolling your child in.

2 mornings/week		\$230
3 mornings/week		\$300
4 afternoons/week		\$395

- 5 mornings available - please inquire with registrar for more information

Child's Full Name: \_\_\_\_\_ Sex: M F

Child's Home Address: \_\_\_\_\_ Date of Birth: (YYYY/MM/DD) \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Primary Phone Number: \_\_\_\_\_

**Primary Parent/Guardian 1:** \_\_\_\_\_

Home Address: Same as Child's € (if different, please indicate) City: \_\_\_\_\_ Postal: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Place of Work: \_\_\_\_\_ *If N/A Please Use Home Address*

Work Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal: \_\_\_\_\_

Email address (primary email): \_\_\_\_\_

**Primary Parent/Guardian 2:** \_\_\_\_\_

Home Address: Same as Child's € (if different, please indicate) City: \_\_\_\_\_ Postal: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Place of Work: \_\_\_\_\_ *If N/A Please Use Home Address*

Work Address: \_\_\_\_\_  
City: \_\_\_\_\_ Postal: \_\_\_\_\_  
Email address: \_\_\_\_\_

Child Care Provider:	Doctor:
Residential #:	Business #:
Business #:	Other:
Cell#:	

**NEAREST CONTACT WHO IS AUTHORIZED TO PICK UP YOUR CHILD IF PARENTS CANNOT BE REACHED:**

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Residential #: \_\_\_\_\_ Business #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Complete Address: \_\_\_\_\_

**SECOND CONTACT IF PARENTS OR NEAREST CONTACT CANNOT BE REACHED**

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_  
Residential #: \_\_\_\_\_ Business #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Complete Address: \_\_\_\_\_

I \_\_\_\_\_ have made the Emergency contacts aware of their responsibility with respect to my child. I understand that 911 may be called if teachers or duty parents feel emergency situation requires immediate medical assistance.

<b>Child's Medical Information</b>
Disabilities: _____
Allergies: _____
Serious Illnesses or Communicable Diseases child has contacted in the past (if any): _____
Please list any other medical information you feel would be useful for teachers to have: _____ _____
<b>THIS WILL CERTIFY THAT THE ABOVE-NAMED CHILD IS FREE FROM COMMUNICABLE DISEASES AND IS ABLE TO PARTICIPATE IN PRESCHOOL ACTIVITIES.</b>

SIGNATURE OF PARENT/GUARDIAN: _____
DATE: _____