

Steinbach Christian Preschool

Registration form

\$30 Registration fee pd _____

Payable to: SCP



STEINBACH CHRISTIAN PRESCHOOL

2017- 2018 SCHOOL TERM

Monday/Wednesday AM 3yrs _____ Monday/Wednesday AM 4yrs _____

Monday/Wednesday PM 4yrs _____ (2 classes)

Tuesday/Thursday AM 3 yrs _____ Tuesday/Thursday AM 4yrs _____

Tuesday/Thursday PM 4 yrs _____ (2 classes)

a ministry of the
Emmanuel Evangelical
Free Church

Friend

Requests: _____

We do our best to accommodate these requests, but cannot promise that they will all be honored.

Child's Name: _____ (male ___ female ___) **Birthdate:** _____
(month /day /year)

Street Address: _____ **Home Phone:** _____

Mailing Address: _____

City/Town _____ **Postal Code:** _____

Parents/guardians: Mother's name: _____ **Mother's phone:** _____

Mother's place of employment: _____ phone: _____

Father's name: _____ **Father's phone:** _____

Father's place of employment: _____ phone: _____

Email address: _____

Please check: Married () Separated () Divorced () Single () Common-law ()

Home Church: _____

PARENT DESIGNATE: who may be contacted in the event of an emergency if **BOTH** parents are not available:

Name: _____ **Phone#** _____

Is this child in the care of a foster agency? Yes _____ No _____

Name of agency:		Name of Social Worker:	
Office Address:			
City:		Postal Code:	
Phone:	Fax:	Email:	

Steinbach Christian Preschool

Names of individuals to whom your child may be released for pick-up from Preschool:
(other than parents):

Name: _____ Ph#: _____

Name: _____ Ph#: _____

Name: _____ Ph#: _____

Name: _____ Ph#: _____

Name: _____ Ph#: _____

Name: _____ Ph#: _____

Medical Consent Form

In the event that my child is ill or injured, and I cannot be reached, I give consent for the Steinbach Christian Preschool provider to refer my child to the family physician. If the physician cannot be reached, I give my consent to have my child taken to the Emergency Department of the hospital listed below.

Child's Name: _____

Birthdate: _____

MEDICAL CONDITIONS: please list any, physical, developmental or emotional conditions relevant to the care of your child: _____

Home Street Address: _____

Home Phone Number: _____

Family Physician: _____

Physician's Address: _____

Physician's Phone Number: _____

Hospital Name: _____

Manitoba Health Family ID #: _____

Manitoba Health Individual 9-digit #: _____

Child's allergies to medication: _____

Parent/Guardian Signature: _____ Date: _____

Social Worker Signature (if applicable) _____ Date: _____

Medical Questionnaire

Child's Name: _____

Please complete the following. Specify **Yes if Doctor or Physician diagnosed.**

1. Life Threatening Allergies Yes No
If yes please specify allergy/allergies:

2. Epipen/auto-injector prescribed Yes No

3. Epipen/auto-injector provided to the centre Yes No

4. Asthma Yes No

5. Inhaler provided to school Yes No

6. Bleeding Disorder Yes No

7. Diabetes Yes No

8. Heart Condition Yes No

9. Seizure Condition Yes No

10. Other significant conditions that are Physician diagnosed (examples: ulcerative colitis, crohns, transplants, spina-bifida, permanent physical limitations, etc)

This medical information is being collected so that an appropriate individual health care plan may be developed. The Steinbach Christian Preschool will share this above information with URIS (unified referral and intake system) if your child has anaphylaxis or a severe medical condition. This program is a partnership between Health, Family services and Housing, Education and Youth.

Parental Child Custody

Family Services requires SCP to have a copy of any court documentation regarding child custody. If this applies to your circumstances please make sure the appropriate paper work is attached.

No, this does not apply to our family.

Yes, this applies to our family and the appropriate documents are attached.

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Parent Policy Consent

I have read and understand the information and procedure as outlined in the Parent Policy Statement.

Name: _____

Parent/guardian Signature: _____ Date: _____

Social Worker Signature (if applicable) _____ Date: _____