



**REGISTRATION FORM**

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 (12:45–3:45 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?

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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):

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

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

Previous School/Daycare Attended: \_\_\_\_\_

Names and ages of siblings: \_\_\_\_\_

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**EMERGENCY HEALTH INFORMATION:**

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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:

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For Office Use Only	Rec'd.	Reg.	Dep.	Class	AM	EX
Observation	Interview	Enrolled	Start Date: _____		PM	