

**Oak Park Neighbourhood Centre Paid Program Registration Form**

Date \_\_\_\_\_

Parents Names \_\_\_\_\_ Caregiver? \_\_\_\_\_

Parent/Guardian Address \_\_\_\_\_ Postal Code \_\_\_\_\_

Parent/Guardian Home Phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Other phone? \_\_\_\_\_ email \_\_\_\_\_

Child's Name \_\_\_\_\_ B-Day \_\_\_\_\_

Emergency Name \_\_\_\_\_ Phone \_\_\_\_\_ Relation to child \_\_\_\_\_

Medical conditions that we should know about?

\_\_\_\_\_

If child has a life threatening allergy or regular medication we need you to fill out additional forms. Please notify staff.

Class \_\_\_\_\_ Day- \_\_\_\_\_ Time \_\_\_\_\_ #Wks \_\_\_\_\_ Paid \$ \_\_\_\_\_ - cash or cheque

Class \_\_\_\_\_ Day- \_\_\_\_\_ Time \_\_\_\_\_ #Wks \_\_\_\_\_ Paid \$ \_\_\_\_\_ - cash or cheque

Class \_\_\_\_\_ Day- \_\_\_\_\_ Time \_\_\_\_\_ #Wks \_\_\_\_\_ Paid \$ \_\_\_\_\_ - cash or cheque

Class \_\_\_\_\_ Day- \_\_\_\_\_ Time \_\_\_\_\_ #Wks \_\_\_\_\_ Paid \$ \_\_\_\_\_ - cash or cheque

**Child Information**

Is your child toilet trained? Yes \_\_\_\_ No \_\_\_\_

Are there other special considerations which you would like the staff to be aware of? (how do they react to new situations; when angry; or frightened. Do they play well with others?etc)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your child's favorite activity? \_\_\_\_\_

Describe how you comfort and reassure your child. \_\_\_\_\_

I acknowledge and understand that participation in and attendance at Oak Park Neighbourhood Centre activities and programs involves certain risks and dangers of accidents. I have considered and evaluated the nature, scope and extent of risks involved, and voluntarily and freely choose to assume those risks.

I release Oak Park Neighbourhood Centre from responsibility and/or liability for any loss, damage or injury that may result while my child(ren) are participating in an Oak Park Neighbourhood Centre event or activity, whether at the Oak Park Neighbourhood Centre or at an Oak Park Neighbourhood Centre being held at another location. This form shall remain in full force and effect until it is withdrawn by giving written notice to Oak Park Neighbourhood Centre. I agree that no notice apart from that, which is specified above, shall be considered to amend this form. I have the authority to give this release.

(Witness)

(Signature of Parent/Legal Guardian)

\_\_\_\_\_

\_\_\_\_\_

Printed names

\_\_\_\_\_

\_\_\_\_\_

## Oak Park Neighbourhood Centre Un-Parented Emergency Treatment Release Form

I authorize Oak Park Neighbourhood Centre to act on my behalf to ensure immediate medical treatment should the staff deem it necessary. I give permission for my child, \_\_\_\_\_, in the event of an emergency, to receive full medical attention deemed necessary by a physician at a hospital. If possible without leaving the centre without sufficient staff, my child will be accompanied to the hospital or met there. Every effort will be made to reach me and/or my emergency contact person. I agree to accept any financial responsibility for any emergency medical care necessary.

Signature of parent/legal guardian: \_\_\_\_\_

Date: \_\_\_\_\_ Witness: \_\_\_\_\_

### Authorized People to Pick Up Child.

The following people are authorized to pick up my child, \_\_\_\_\_ from Oak Park Neighbourhood Centre.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

**Please list any individual(s) who is LEGALLY DENIED access to your child:**

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**A written consent letter is required for pickup by anyone not on this list.**

## **Oak Park Neighbourhood Centre Drop Off Health checklist**

### **Children cannot attend the program if they...**

- Don't feel well enough to participate
- Have a temperature that is above normal
- Have a headache that is affecting their ability to interact
- Have diarrhea
- Have strep throat or impetigo (isolated for 24 hrs after treatment begins)
- Have an eye infection (isolated for 24 hrs after treatment begins)
- Have discharge from the ear or eye
- Have an earache
- They require care that the teachers are not able to provide.
- Are extremely sleepy
- Are having trouble breathing
- Have vomited 2 or more times in the last 24 hours.
- Are unable to tolerate normal food or drink due to illness
- Have a severe cough
- Have a skin rash from an undetermined cause
- Have head lice or scabies (must have one treatment to return)
- Have chickenpox (safe to return after sores are crusted over usually 7 days)
- Have hepatitis A (safe to return 7 days after the jaundice began)
- Have pertussis (Safe to return after 5 days of antibiotics)
- Have tuberculosis, measles, shingles, E.Coli, or Shigella (Dr. must provide signed note saying they are no longer contagious)