Oak Park Neighbourhood Centre Preschool Program Registration Form Date_____

Child's Name_____ B-Day_____

Address_____ Postal Code_____ Phone_____

Caregiver Name and phone _____

2nd Address- specify parent/caregiver_____

2nd Address_____ Postal Code _____ Phone_____

Parents' Names 1. _____ Parent 2._____
Work Name, address, postal & Phone: Work Name, address, postal & Phone:

_____ _____

_____ _____

Email_____ Email_____

Cell phone_____ Cell phone_____

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.

Doctor name/Address/Postal/Phone_____

Day preferred – Tuesday ❑ Wednesday ❑ Thursday ❑ Friday ❑ 9:30-Noon each day
Paid $105 for every 4 days – 10 post-dated cheques rec'd _____ Post-dated cheques for the year are required.
There is a $35 non-refundable registration fee due at time of registration.
Deposit received date_____ Immunization form received date _____

Child Information
Is your child toilet trained? Yes ____ No ____

Any information that you would like us to be aware of? (how do they react to new situations; when angry; or frightened. Do they play well with others? What is their favorite activity? etc.)
_____
_____
_____

Describe how you comfort and reassure your child._____

_____

_____

Preschool Waiver, Medical Emergency & Pick Up Authorization

Child Name_____ Date:_____

I acknowledge and understand that participation in and attendance at Oak Park Neighbourhood Centre preschool 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 the preschool, whether at the Oak Park Neighbourhood Centre or in the grounds surrounding it. This form shall remain in full force and effect until it is withdrawn by giving written notice to Oak Park Neighbourhood Centre.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.
I have read the parent handbook and I agree to comply with the policies contained in it. At this time I wish to enter into an agreement with Oak Park Neighbourhood centre Preschool to provide care for my child.

Signature of Parent/Legal Guardian_____

Oak Park Neighbourhood Centre 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 hospital physician. If possible my child will be accompanied to the hospital or met there by staff. Every effort will be made to reach me and/or my emergency contacts. I agree to accept any financial responsibility for any emergency medical care necessary.

Signature of Parent/Guardian:_____

Authorized People to Pick Up my Child.

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:

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

Signature of Parent/Guardian: _____

Permission to Use Photograph

I grant to Oak Park Neighbourhood Centre the right to take photographs of myself or my child in connection with OPNC programs. I authorize Oak Park Neighbourhood Centre, its assigns and transferees to copyright, use and publish the same in print and/or electronically.
I agree that the Centre may use such photographs with or without names and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.
I have read and understand the above:

Signature, Parent/Guardian: _____

Preschool Program Immunization Form

The Immunization of School Pupils Act, 1982, requires your child to be immunized against six diseases: measles, mumps, rubella (German Measles), diphtheria, tetanus and polio. This requirement can only be removed if you object to immunization for medical, conscience or religious reasons and you have completed the necessary exemption form obtained from the Health Department.

Student's Name _____

Please fill in all dates of Immunization since birth:

Vaccine Dates Given (y/m/d)	Diptheria	Pertussis (Whopping Cough)	Tetanus	Polio – IPV or OPV (please specify)	Hib – (Haemophilus influenza – type B)	Measles	Mumps	Rubella	Meningococcal – C	Prevnar	Hepatitis B	Varicella (Chicken Pox)

Collection of this information is authorized under the Immunization of School Pupils Act, 1982. This information is used by the medical officer of health to maintain an immunization record for this child and take appropriate action to prevent vaccine preventable diseases. For further details concerning this collection, contact the Halton Region Health Department 905-825-6000.