

Oak Park Neighbourhood Centre Preschool Program Registration Form Date Admitted _____

Child's Name _____ Birth Day _____

Parent 1 Name _____

Address1 _____ Postal Code _____ Phone _____

Parent 2 Name _____

Address2 _____ Postal Code _____ Phone _____

2nd Language? _____ Yrs in Canada _____

Parent 1. Employment Details for Emerg. Contact

Parent 2. Employment Details for Emerg. Contact

Workplace: _____

Workplace: _____

Address _____

Address _____

Email _____

Email _____

Phone _____

Phone _____

Emergency Name _____ Phone _____ Relation to child _____

Any communicable diseases or conditions requiring medical attention 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.

Days Enrolled – Monday Tuesday Wednesday Thursday Friday 9:30-12:00 or 1-3:30

Monthly Rate	1 day a wk	2 days a wk	3 days a wk	4 days a wk	5 days a wk
9:30-noon or 1-3:30	\$115	\$225	\$325	\$428	\$525

Post-dated cheques for the year are required.

There is a \$35 non-refundable administration fee due at time of registration. \$10 fee for bounced cheques.

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. _____

Immunization Rec'd _____

Discharge Date _____

Cheques Rec'd Details _____

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 This form shall remain in full force and effect until it is withdrawn by giving written notice to Oak Park Neighbourhood Centre.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 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 the OPNC preschool program. 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 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)	Diphtheria	Pertussis (Whooping 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.