



# WESTERN QUEBEC SCHOOL BOARD DAYCARE REGISTRATION FOR 2016-2017

## Confirmation of Student Information Eardley Daycare

### STUDENT IDENTIFICATION

STUDENT'S FAMILY NAME \_\_\_\_\_ STUDENT'S FIRST NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_

PERMANENT CODE \_\_\_\_\_ I.D. No. \_\_\_\_\_ STUDENT'S HOME PHONE \_\_\_\_\_

ADDRESS STUDENT \_\_\_\_\_

ADULT RESPONSIBLE: FATHER  MOTHER  GUARDIAN  IF APPLICABLE PLEASE INDICATE JOINT CUSTODY

\_\_\_\_\_ AUT.P/U FATHER'S NAME  \_\_\_\_\_ AUT.P/U MOTHER'S NAME  \_\_\_\_\_ AUT.P/U GUARDIAN'S NAME

FATHER HOME PHONE \_\_\_\_\_ FATHER WORK \_\_\_\_\_ FATHER CELL/PAGER \_\_\_\_\_ ADDRESS FATHER \_\_\_\_\_

MOTHER HOME PHONE \_\_\_\_\_ MOTHER WORK \_\_\_\_\_ MOTHER CELL/PAGER \_\_\_\_\_ ADDRESS MOTHER \_\_\_\_\_

GUARDIAN HOME PHONE \_\_\_\_\_ GUARDIAN WORK \_\_\_\_\_ GUARDIAN CELL/PAGER \_\_\_\_\_ ADDRESS GUARDIAN \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Emergency contacts listed below will be called in the order listed. Please indicate whether the emergency contact is authorized to pick up your child by check marking the box provided.

\_\_\_\_\_ AUT.P/U EMERGENCY CONTACT #1 NAME EMERG. CONTACT #1 (HOME) EMERG.CONTACT #1 (WORK) EMERGENCY CONTACT #1 ADDRESS

\_\_\_\_\_ AUT.P/U EMERGENCY CONTACT #2 NAME EMERG. CONTACT #2 (HOME) EMERG.CONTACT #2 (WORK) EMERGENCY CONTACT #2 ADDRESS

### DAYCARE ATTENDANCE

### MEDICAL INFORMATION

\* PLEASE INDICATE THE DAYS AND TIMES THAT THE STUDENT WILL ATTEND THE DAYCARE

MEDICAL CARD NUMBER \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_

	M	T	W	T	F	
AM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	REGULAR <input type="checkbox"/>
LUNCH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SPORADIC <input type="checkbox"/>
PM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*(Please see below)

ALLERGIES: NO  YES  (PLEASE SPECIFY) \_\_\_\_\_

DOES HE/SHE HAVE AN EPIPEN? NO  YES

ASTHMA: NO  YES  INHALER AT SCHOOL? NO  YES

DIABETES: NO  YES  EPILEPSY: NO  YES

DOES HE/SHE TAKE ANY MEDICATION? \_\_\_\_\_

FOR INCOME TAX PURPOSES, PLEASE PROVIDE US WITH THE SOCIAL INSURANCE NUMBER OF THE PARENT/GUARDIAN WHO WILL BE CLAIMING THE DAYCARE EXPENSES.

Name	SIN
Father: _____	_____
Mother: _____	_____
Guardian: _____	_____

MAIN PAYER  
*For Official tax receipt purposes*

STUDENT'S START DATE AT DAYCARE: \_\_\_\_\_

PARENT/GUARDIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

\* 3 or more days per week on a regular basis  
Maximum charge is \$8.10/day for 5 hours or less per day

\* Professional Development  
Day charge is \$16.10/day for 10 hours or less per day

Rates subject to the rules and regulations governed by MEES