Grade 8 - 12
REGISTRATION FORM

STUDENT'S INFORMATION

Legal Last Name: _____ **Legal Middle Name:** _____

Legal First Name: _____

Preferred Name: _____ **Date of Birth (D/M/Y):** _____

Gender: € Male € Female **Grade Assignment:** _____

Birth Place: _____ **Birth Country:** _____

Birth Certificate #: _____ **Copy of Birth Certificate:** € Yes € No

Home Language: _____ **Aboriginal Ancestry:** € Yes € No

Copy of Status Card: € Yes € No

Band Name: _____

Status Number: _____

Student's Physical Address: _____

Student's Mailing Address: _____

Previous School (if applicable): _____

Previous School Address (if known): _____

MOTHER/GUARDIAN'S INFORMATION

First & Last Name: _____ **Home Phone:** _____

Employer: _____ **Cell Phone:** _____

Physical Address: _____ **Work Phone:** _____

Mailing Address: _____

FATHER/GUARDIAN'S INFORMATION

First & Last Name: _____ **Home Phone:** _____

Employer: _____ **Cell Phone:** _____

Physical Address: _____ **Work Phone:** _____

Mailing Address: _____

EMERGENCY CONTACT INFORMATION

Contact 1: _____ **Home Phone:** _____

Relationship to Student: _____ **Cell Phone:** _____

Contact 2: _____ **Home Phone:** _____

Relationship to Student: _____ **Cell Phone:** _____

BUSSING

Will your child be taking the bus? € **Yes** € **No**

If yes, physical address where your child will be picked up/dropped off? _____

CUSTODY AGREEMENT

If there is a custody agreement in place, please provide details you wish for Chalo School staff to be aware of (we require a copy of this agreement and a copy will be placed in the child's file):

_____

_____

_____

EMERGENGY MEDICAL CONSENT

In the case of illness or accident involving my child and if, for any reason, I cannot be reached, I hereby authorize Chalo School staff or representatives to send for or have my child taken to:

Family Doctor: _____ **Phone Number:** _____

Family Dentist: _____ **Phone Number:** _____

Should the above not be available, I agree that Chalo School staff or representatives, in an emergency, may call upon the local hospital or ambulance. All costs incurred are the responsibility of the parent/guardian of the child.

Printed Name of Parent: _____

Signature of Parent/Guardian: _____ **Date of Signature:** _____

STUDENT'S HEALTH INFORMATION

Health Care Card Number: _____ **Copy of Health Care Card:** € **Yes** € **No**

Does your child have any of the following:

Vision Problems? **Yes** **No** **Hearing Problems?** **Yes** **No** **Speech/Language Problems?** **Yes** **No**

Take medication? **Yes** **No**

Specify and comment on items marked 'Yes':

_____

Allergies: _____ **Life Threatening:** **Yes** **No**

Print Name of Parent/Guardian _____ **Signature of Parent/Guardian** _____

Date of Registration _____

School Authorization _____ **Position** _____

Date of Registration _____

CHALO SCHOOL
PERMISSION FORM

From time to time, over the school year, your child will be leaving the school grounds for a short day trip (field trip). Individual classroom teachers will notify parents of upcoming day trips through their newsletters. The school needs to have, on file, a statement of authorization signed by the parent or guardian in order for the child to participate in these day trips. Please indicate your choice, with a check mark below, regarding your child and return to the school as soon as possible.

_____ _____

Child's Name (Print) **Child's Teacher**

I authorize my child to take part in occasional day trips. **Yes**

I do not wish for my child to take part in day trips. My child will remain at the school in the classroom. **No**

Print Parent/Guardian's Name _____

Parent/Guardian Signature _____

Date _____

CHALO SCHOOL
CONSENT FOR USE OF PERSONAL INFORMATION

In accordance with the Freedom of Information and Protection of Privacy Act, Chalo School requires consent to use personal information for purposes unrelated to educational programs.

1. There are occasions when our school would like to have contact with parents to consult them directly about school issues or meetings, or to plan school related activities. To contact you for these purposes, we need consent for the disclosure of your name, home address, and phone number to Chalo School employees, our Parent Advisory Council or others responsible for organizing these types of activities. Your personal information will not be disclosed to anyone for business or commercial purposes.

I give my consent for release of my home address and phone number for purposes consistent with the above. **Yes**

I do not give my consent for release of my home address and phone number for purposes consistent with the above. **No**

2. It is a tradition in our school to allow staff and the media to photograph individual students and groups of students to commemorate events and to promote various educational, sport, and cultural events taking place in the school. While photographs add to the community life of our school, they are not required for educational purposes. As such, consent for the release of your child's name, photograph, and comments is required. Students' names, photographs, and comments may be published in the school yearbook or newsletter, and on occasion, in the news media.

I give my consent for the publication of my child's name, photograph, and comments for purposes consistent with the above. **Yes**

I do not give my consent for the publication of my child's name, photograph, and comments for purposes consistent with the above. **No**

Print Parent/Guardian's Name _____

Parent/Guardian Signature _____

Date _____

CHALO SCHOOL
LETTER OF AUTHORITY – MEDICATION

The purpose of this form is to provide the School Principal with the necessary information and authority to administer medication to pupils who require it in order to function satisfactorily in school activities. This form must be completed and signed by Physician before administration of medication.

Attending Physician: _____

Telephone Number of Physician: _____

Ailment: _____

Medication Prescribed: _____

Prescribed administering directions: _____

Exact dosage: _____

Consequences of missing medication/incorrect dosage: _____

Emergency Procedures: _____

Side effects: _____

I consider that the above medication and administration thereof during the school day to be in the best interest of the above named pupil, and hereby authorize its administration by the School Principal or delegate.

Attending Physician: _____

I hereby authorize the School Principal or designate to administer the medication as described above to my son/daughter and to contact the physician named above should there be any further questions or concerns. I further authorize the physician to release any information pertinent to this matter.

Signature of Parent/Guardian: _____