



# APPLICATION FORM

*Teaching to change lives the Bible Way*

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

## CHILD'S INFORMATION:

Full Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Sex: \_\_\_\_\_ Address: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Mother's Name	_____		
Address (If different from above)	_____		
	Postal Code	_____	
Employer	Home Phone	_____	
Business Phone:	Cell Phone:	_____	

Father's Name	_____		
Address (If different from above)	_____		
	Postal Code	_____	
Employer	Home Phone	_____	
Business Phone:	Cell Phone:	_____	

## EMERGENCY INFORMATION:

In case of emergency and we are unable to contact either parent, who can we call?

Name: \_\_\_\_\_ Phone No: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Business No: \_\_\_\_\_

## Persons authorized to take child from centre

Please note: Advanced, written authorization must be provided for anyone who is not on the list:

Name	Relationship to Child	Address	Phone No's

Signed: \_\_\_\_\_

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

**CITIZENSHIP:**

Canadian                       Landed Immigrant                       Student Visa                       Other Visa

If not Canadian citizen, please specify date of entry to Canada: \_\_\_\_\_

**HEALTH INFORMATION:**

Name of Child: \_\_\_\_\_

Sex \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Doctors Name \_\_\_\_\_ Health Card No: \_\_\_\_\_

Doctors Address \_\_\_\_\_ Postal Code: \_\_\_\_\_

Has the child suffered from any contagious illness within the past two weeks (measles, chicken pox

Yes     No                      (If yes, please specify) \_\_\_\_\_

Does the child suffer from any ongoing illness (asthma, epilepsy, allergies, diabetes, etc)

Yes     No                      (If yes, please specify) \_\_\_\_\_

**Consent for Emergency Medical Treatment**

In the case of an emergency due to an accident, sudden illness or any other emergency situation, Medical treatment may be administered by a physician or hospital staff including anesthetic if necessary. However, if at anytime emergency medical treatment is required every possible effort will be made to contact the parent or guardian of the child.

Medication can be administered by a staff member provided it is a current prescription in the original container with the child's name on the label. Non-prescription medication will not be administered by a staff member. All medication must be given to a staff member to be stored in the appropriate lockable container. A medication form must be signed daily by the parent/guardian to authorize staff to administer medication.

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**OFFICE USE ONLY**

Admission Date: \_\_\_\_\_

S.K                       Grade 1-8                       Before and After School

Fees Monthly:                      \$ \_\_\_\_\_                      Bi-Weekly                      \$ \_\_\_\_\_

Drop off Time: \_\_\_\_\_ Pick up Time: \_\_\_\_\_

**Proof of Age and Name**

Birth Certificate     Passport                       Baptismal Certificate                       OSR                       Other