REGISTRATION FORM

Child's Name: ______________________________ Sex: ____ D.O.B: __________________________

Home Address: ____
No. Street Name City/Prov. Postal Code

Home #: ______________________ Health Card No.______________________________________

E mail: ____

Mother's Name: ________________________________ Work #__________________________________

Cell # _________________________________

Work Address: ____
No. Street Name City/Prov. Postal Code

Father's Name: ________________________________ Work #__________________________________

Cell # __________________________________

Work Address: ____
No. Street Name City/Prov. Postal Code

Person to be contacted if parents cannot be reached/ Persons Authorized to pick up my child:

Name: ________________________Cell #_______________________ Work #_____________________

Name: ________________________Cell#________________________ Work# _____________________

Dr.'s Name: ________________________ Phone#_______________________________

Address____
No. Street Name City/Prov. Postal Code

** Please attach a copy of your child's immunization record**

My child has the following medical conditions /allergies /food restrictions:

If, at any time, due to such circumstances, an accident, sudden illness or emergency medical treatment is required, your child may be transported to the hospital via Ambulance to seek further medical attention. The centre will try to contact the parents before any arrangements are made.

____________________________ ____________________________ ___________________

Parent Signature Child's name Date

How did you hear about us? ____

****NOTE**** Registration NOT complete until parent has been to the Centre and received confirmation from the Supervisor. Thank you!