EARLY DISCOVERIES

Ph. (403)239-3444 Email: registration@earlydiscoveries.ca

☐ Hawkwood	☐ 3 yr	☐ Mon	☐ AM
☐ Kincora	☐ 4 yr	☐ Tue	☐ PM
☐ Parkdale	☐ Kinder	☐ Wed	
☐ Redstone	☐ Step	☐ Thur	
☐ Thorncliffe	☐ _____	☐ Fri	

Family Information

Child's Name_____ Name used_____ Male___ Female__
first middle last

Date of Birth **(d/m/y)** _____

Address _____ Postal Code_____

Language Spoken _____ Home ph _____ Email _____

Mother's Name_____ Occupation_____

Employer _____ Bus ph _____ Cell ph _____

Address if different from child's_____

Father's Name_____ Occupation_____

Employer _____ Bus ph _____ Cell ph _____

Address if different from child's_____

Household members: sibling's name _____ Age _____

sibling's name _____ Age _____

Other members _____

Has your child been in preschool before? Y/N If yes, where? _____

Emergency Contact Person (other than Parents)

Name _____ Phone _____ Cell Phone _____

Address _____ Postal Code_____

Persons authorized to pick up your child _____

Health Information

Allergies/Sensitivities_____ Chronic Conditions _____

Does your child require any medication? If so, please indicate medication. _____

Medication should be kept at school. If you choose to bring it back and forth, your child will not be able to attend class unless the medication is present.

Concerns Speech: **Y / N** Other: _____

Is your child currently receiving or have they received any funded services from therapists/agencies? **Y / N**

If yes, from whom? _____

_____

Has your child had any medical or emotional condition requiring treatment? If yes, please explain.

_____

*** NOTE: We no longer accept funded children from outside agencies.**

Consent for medical attention

I give authority for my child's teacher to take the necessary steps to ensure that my child receives the care needed in any emergency. I also understand that I would be contacted immediately when any care is required. If a staff member from Early Discoveries needs to summon an ambulance, then I will be responsible for the cost incurred. As well, I understand that if my child has a diagnosed allergy/medical condition requiring medication, I will provide the prescribed medication to the school to be kept at the school. If I choose to bring the medication back and forth, I am aware that my child cannot attend if I forget the medication.

Parent's signature: _____

The Alberta regulations require that each school be aware of whether a child is immunized or not.

_____ My child's immunization is up to date as of _____ (today's date)

_____ My child has not been immunized for the following and/or not at all:

_____

We only ask about immunization records in case an outbreak occurs in the class/school. Then, we can notify families whose children are not immunized.

Consent for Field Trips

I hereby give permission for my child to participate in all the day to day school activities such as nature walks, trips to the park and outside snack and story times. I authorize the preschool/Kindergarten to include my child in all field trips planned for the school year. If I object to any trips then I will keep my child home on that day. It is my understanding that the teacher will inform me of any class trips other than short walking trips, and I will be required to sign a permission slip to show my agreement with the plans.

Signature of parent _____

Speech and OT screening (KINDERGARTEN ONLY)

As part of our Kindergarten program, we provide a speech and OT screening in September. The screening is conducted by our speech pathologist and our occupational therapist. If the therapist finds that your child needs additional help in these areas, she will contact you and let you know.

If you would like to have your child screened for speech and/or OT, please sign below. If you do not want your child to be screened, please check below.

_____ Yes, I would like to have my child screened for speech. _____(signature)

_____ Yes, I would like to have my child screened for fine motor skills (OT). _____(signature)

_____ No, I do not want my child to be screened for speech.

_____ No, I do not want my child to be screened for OT.

If you consent to your child being screened and the therapist(s) determine your child needs assistance, your signature above implies you agree to your child receiving therapy.

Payment Information Required

Automatic EFT Payment:

Branch Transit Number: _____

Financial Institution Number: _____

Account Number: _____

*** Non-refundable registration fee of $100 will be added to first payment**

Account holder name: _____

Account holder signature: _____

Payments from your account will show up as Early Discoveries or EDNS

I agree to give Early Discoveries one month's notice of withdrawal/absence or I will forfeit one month's payment. I understand that no refunds for the current school year are given after May 1st. I also understand the registration fee is non-refundable.

Signature: _____