STUDENT REGISTRATION FORM

(one form per student please)

Calvin Christian Elementary
245 Sutton Ave., Winnipeg, MB R2G 0T1
Phone: 204-338-7981 Fax: 204-339-3280

Calvin Christian Collegiate
706 Day St., Winnipeg, MB R2C 1B6
Phone: 204-222-7910 Fax: 204-222-8511

This personal information is being collected under the authority of the Public Schools Act and will be used for educational purposes. It is protected by the Protection of Privacy provisions of The Freedom of Information and Protection of Privacy Act. If you have any questions about the collection, contact the campus principal at the number listed above.

Entering Grade _____, **School Year 20 /20**

NAME: Last: _____ First: _____ Middle: _____

☐ Male ☐ Female Birthdate ____/____/____ Home phone: _____ Unlisted? ☐ Yes ☐ No
mm dd yy

Last school attended: _____

LEGAL NAMES *(if different from above)*:
Last: _____ First: _____ Middle: _____

In which school division do you reside? _____

Home address: _____ _____ _____
Street *City/Town* *Postal Code*

Student's 9-digit MB Medical _____

Family 6-digit MB Medical _____

CUSTODY: Are there any legal restrictions to this child? ☐ No ☐ Yes (a copy of legal documents must be filed at school)

Parent/guardian: *(list in order of priority to call)*

1. **Name**: Last: _____ First: _____ ☐ Mr. ☐ Mrs. ☐ Ms.
   Relationship: _____ Legal Guardian? ☐ Yes ☐ No
   Employer: _____ Work Phone: _____ Cell: _____
   Address/Home Phone *(if different from above)*:
   _____ _____ _____ _____
   Street *City/Town* *Postal Code* *Home Phone*
2. **Name**: Last: _____ First: _____ ☐ Mr. ☐ Mrs. ☐ Ms.
   Relationship: _____ Legal Guardian? ☐ Yes ☐ No
   Employer: _____ Work Phone: _____ Cell: _____
   Address/Home Phone *(if different from above)*:
   _____ _____ _____ _____
   Street *City/Town* *Postal Code* *Home Phone*
3. **Name**: Last: _____ First: _____ ☐ Mr. ☐ Mrs. ☐ Ms.
   Relationship: _____ Legal Guardian? ☐ Yes ☐ No
   Employer: _____ Work Phone: _____ Cell: _____
   Address/Home Phone *(if different from above)*:
   _____ _____ _____ _____
   Street *City/Town* *Postal Code* *Home Phone*

Emergency Contact *(someone who can take immediate action in the event we are unable to contact any of the above people)*

Name: _____ Relationship: _____ Phone: _____

Siblings

Name: _____ Age: _____ Grade: _____ School: _____

Name: _____ Age: _____ Grade: _____ School: _____

Name: _____ Age: _____ Grade: _____ School: _____

Signatures: *(verifying the above information is true and correct)*

Parent/guardian _____ or student _____
(if 18 years or older)

Date _____

Upon transfer/withdrawal of a student, the pupil file will be forwarded to the next school of attendance.

MEDICAL QUESTIONNAIRE

Please complete the following. Specify "yes" if physician diagnosed.

1.	Life threatening allergy	☐ Yes	☐ No	If yes, specify: _____
2.	Prescribed an EpiPen	☐ Yes	☐ No	
3.	Asthma	☐ Yes	☐ No	
4.	Bleeding disorder	☐ Yes	☐ No	
5.	Diabetes	☐ Yes	☐ No	
6.	Heart condition	☐ Yes	☐ No	
7.	Seizure disorder	☐ Yes	☐ No	

8. Other **significant** conditions that are physician diagnosed (i.e. ulcerative colitis, Crohns, transplants, spina bifida, permanent physical limitations)

This medical information is being collected so that appropriate health care plans may be developed and may be necessary to obtain funding. This information will only be shared with appropriate individuals. This information is protected by the Personal Health Information Act. Questions should be directed to the campus principal.

SUPPORT SERVICES

Please indicate if student has utilized any of the following services:

☐ Resource	☐ School counselor	☐ Reading
☐ Psychology	☐ Psychiatry	☐ Speech & language
☐ Social work	☐ Occupational therapy	☐ Physiotherapy
☐ Outside agency	☐ Child in care	☐ _____

If any services above are checked (✓), please complete details below.

Name of agency/support service: _____

Name of contact person: _____

Address: _____ Phone _____

Briefly describe the reason for service:

Name of agency/support service: _____

Name of contact person: _____

Address: _____ Phone _____

Briefly describe the reason for service:

The Support Services information is being collected so that appropriate educational services may be provided for your son/daughter. This information will only be shared with appropriate individuals. This information is protected by the Freedom of Information and Protection of Privacy Act. Questions should be directed to the campus principal.

ABORIGINAL IDENTITY DECLARATION

Aboriginal Identity Declaration helps to support the efforts of Manitoba Education and Training to plan and improve programs in a way that is responsive to Aboriginal learners. **Providing this personal information is voluntary and optional.** It is being collected in compliance with section 36(1)(b) of the Freedom of Information and Protection of Privacy Act (FIPPA) as it is necessary for and relates directly to the activity of Manitoba Education and Training to plan, deliver and improve programs.

I, _____ (name of parent/guardian, please print clearly):

- ☐ Am submitting my child's Aboriginal Identity Declaration for the first time
- ☐ Am making changes to my child's Aboriginal Identity Declaration
- ☐ Already submitted my child's Aboriginal Identity Declaration and have no further changes to make at this time

Is your child an Aboriginal person, that is, First Nation (North American Indian), Métis or Inuk (Inuit)?
Note: First Nations (North American Indian) include Status and Non-Status Indians)

If "yes," check the box(es) that best describe(s) your child now:

- ☐ Yes, First Nation (North American Indian)
- ☐ Yes, Métis
- ☐ Yes, Inuk (Inuit)

What best describes your child's Aboriginal cultural-linguistic identity? Please select up to two choices:

- ☐ Anishinaabe (Ojibway/Saulteaux)
- ☐ Ininiw
- ☐ Dene (Sayisi)
- ☐ Dakota
- ☐ Oji-Cree
- ☐ Michif
- ☐ Inukitut
- ☐ Other: Please specify _____