KINDERGARTEN 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 Kindergarten, School Year 20 ___ / 20 ___

NAME: Last: _____ First: _____ Middle: _____

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

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 _____

Student lives with: ☐ Both parents ☐ Father ☐ Mother ☐ Guardian ☐ Other:_____

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 (even if not attending school)

Full Name	Date of Birth	Current School
Full Name	Date of Birth	Current School
Full Name	Date of Birth	Current School

Living and Custody Arrangements

If applicable, are there any separation agreements, court orders or other documents setting out custody arrangements for the child? ☐ Yes ☐ No

Have copies been provided to Calvin Christian School? ☐ Yes ☐ No ☐ Will be provided

Are you aware that CCS cannot ask the police to enforce custody arrangements if documents are not provided? ☐ Yes ☐ No

Is the child a ward of Child and Family Services (CFS)? ☐ Yes ☐ No
Name of worker:_____
Phone number of worker:_____
Email address of worker:_____
Name of agency: _____

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.

SOCIAL DEVELOPMENT

Does/has your child attended:

☐ Preschool Name: _____
☐ Daycare Center Name of center: _____
☐ Private Daycare

Does/has your child attended any of the following:
☐ Sunday School ☐ Leisure Guide activities (or similar)
☐ Sports (swimming, Timbits soccer, etc.)

Toileting:
☐ My child is fully independent
☐ My child requires minimal support
☐ My child wears a pull-up and requires support

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. Diabetes ☐ Yes ☐ No
5. Other **significant** conditions that are physician diagnosed (i.e. bleeding disorder, heart condition, seizure disorder, ulcerative colitis, Crohns, transplants, spina bifida, permanent physical limitations)

SUPPORT SERVICES
Please indicate if student has utilized any of the following organizations or services:

☐ Speech & Language	☐ Physiotherapy	☐ SSCY Centre
☐ Psychology/Psychiatry	☐ Social work	☐ St. Amant
☐ Occupational Therapy	☐ Respite	☐ MATC
☐ Audiology (ie. Hearing aids)	☐ Other _____	

If any services above are checked (✓), please complete details below. Please provide any reports that you have.

Name of agency/support service: _____

Name of contact person: _____ Phone _____

Briefly describe the reason for service:

_____

Name of agency/support service: _____

Name of contact person: _____ Phone _____

Briefly describe the reason for service:

_____

The medical information is being collected so that appropriate health care plans may be developed. 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 _____