

# GRADES 1 – 12 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 \_\_\_\_\_

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.

**A copy of last year's report cards must accompany this application.** As needed, an academic screening may be performed for all incoming students. We will be contacting previous schools to obtain a complete picture of the academic and other needs of your children. To facilitate this process, please inform your child's teacher (and resource teacher, if necessary) that our resource department will be calling.

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## 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)

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## SUPPORT SERVICES

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

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Speech & Language            | <input type="checkbox"/> Physiotherapy     | <input type="checkbox"/> SSCY Centre |
| <input type="checkbox"/> Psychology/Psychiatry        | <input type="checkbox"/> Social work       | <input type="checkbox"/> St. Amant   |
| <input type="checkbox"/> Occupational Therapy         | <input type="checkbox"/> Respite           | <input type="checkbox"/> MATC        |
| <input type="checkbox"/> Audiology (ie. Hearing aids) | <input type="checkbox"/> School Counsellor | <input type="checkbox"/> Other _____ |

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

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.

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## 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 \_\_\_\_\_