

CALVIN CHRISTIAN SCHOOL KINDERGARTEN STUDENT REGISTRATION FORM

Elementary Campus

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

Collegiate Campus

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.

STUDENT INFORMATION (PLEASE PRINT) (one form per student)

Applying for Grade _____ School Year 20 ____ / 20 ____

LEGAL NAME: Last: _____ First: _____ Middle: _____

Birthdate ____ / ____ / ____ Male Female Home phone: _____
MM DD YYYY

Home address: _____
Street City Postal Code

Last school attended: _____

What is your present school division? RETSD Sunrise Winnipeg Other _____

Student's 9-digit MB Medical

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Family 6-digit MB Medical

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Student live(s) with: Both parents Father Mother Guardian

Other: _____

CONTACT INFORMATION

Are there any legal restrictions to this student (ie. separation agreements, court orders or other documents setting out custody arrangements for the child)? Yes No (if yes, a copy of legal documents must be on file at the school)

List in order of priority to call:

1st/Primary Contact: (please print)

Name: First: _____ Last: _____ Mr. Mrs. Ms.

Relationship: _____ Legal Guardian? Yes No

Email Address: _____ Has custody of student? Yes No

Cell Phone: _____ Home Phone: _____

Employer: _____ Work Phone: _____

Address (if different from above): _____

Street City/Town Postal Code Home Phone

2nd Contact:

Name: First: _____ Last: _____ Mr. Mrs. Ms.
 Relationship: _____ Legal Guardian? Yes No
 Email Address: _____ Has custody of student? Yes No
 Cell Phone: _____ Home Phone: _____
 Employer: _____ Work Phone: _____
 Address (if different from above):

Street *City/Town* *Postal Code* *Home Phone*

3rd Contact/Emergency Contact: (not a parent, someone who can take immediate action in the event we are unable to contact any of the above people)

Name: First: _____ Last: _____ Mr. Mrs. Ms.
 Relationship: _____ Legal Guardian? Yes No
 Email Address: _____ Has custody of student? Yes No
 Cell Phone: _____ Home Phone: _____
 Employer: _____ Work Phone: _____
 Address (if different from above):

Street *City/Town* *Postal Code* *Home Phone*

4th Contact (optional)

Name: First: _____ Last: _____ Mr. Mrs. Ms.
 Relationship: _____ Legal Guardian? Yes No
 Email Address: _____ Has custody of student? Yes No
 Cell Phone: _____ Home Phone: _____
 Employer: _____ Work Phone: _____
 Address (if different from above):

Street *City/Town* *Postal Code* *Home 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

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 agency: _____

Name of worker: _____

Phone number of worker: _____

Email address of worker: _____

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 the most recent report cards must accompany this application. As needed, an academic screening may be performed for all incoming students. We will contact previous schools to obtain a complete picture of the academic and other needs of your child(ren).

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
- Sports (swimming, Timbits soccer, etc.)
- Leisure Guide activities (or similar)

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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, specify: _____ |
| 2. | Prescribed an EpiPen | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| 3. | Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| 4. | Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 services:

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

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

Name of agency/support service: _____

Contact person: _____ Phone _____

Address: _____

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:

- | | |
|--|-----------------------------------|
| <input type="checkbox"/> Anishinaabe (Ojibway/Saulteaux) | <input type="checkbox"/> Michif |
| <input type="checkbox"/> Ininiw | <input type="checkbox"/> Inukitut |
| <input type="checkbox"/> Dene (Sayisi) | <input type="checkbox"/> Dakota |
| <input type="checkbox"/> Oji-Cree | |
| <input type="checkbox"/> Other: Please specify _____ | |