



Travel OSC Registration Forms September 2016 - June 2017

Travel OSC PM
 Travel OSC PM + Pro-Day
 AM + Travel OSC PM
 AM + Travel OSC PM + Pro-Day

Child Information

 Surname First Middle
 Address: _____
 Street Postal Code
 Phone# _____ Sex: __ M __ F DOB: ___/___/___
 Y M D
 Grade Entering: _____

Parent /Guardian Information

Name: _____ **Phone #:** _____
Address: _____ **Email:** _____
Place of Work: _____ **Phone #:** _____
Name: _____ **Phone #:** _____
Address: _____ **Email:** _____
Place of Work: _____ **Phone #:** _____

PERSONS (OTHER THAN PARENT) AUTHORIZED TO PICK CHILD UP

Name: _____ **Phone #:** _____
Name: _____ **Phone #:** _____
Name: _____ **Phone #:** _____

PERSONS NOT PERMITTED ACCESS TO CHILD

Name: _____ **Phone:** _____
Name: _____ **Phone:** _____

Staff Only: Date of Enrollment _____
 Deposit Received \$100 Y/ N rec'd by _____
 Resource Fee Received \$25 Y/ N rec'd by _____
 2016/17 Parent Package Policy Agreement Signed Y/N

Emergency Permission

It is the facility's policy to notify the parent when a child is ill or requires medical attention. If we are unable to contact the parent and the child needs immediate medical help, parental consent is necessary for facility staff to take appropriate action on behalf of the child. Your consent will accompany the child to the emergency service.

I hereby authorize the staff at Oaklands Community Centre to call a medical practitioner or ambulance for my child, _____ in case of accident or illness if I cannot immediately be reached. If such an emergency should arise, I shall be notified as soon as possible. I agree that I shall be solely responsible for any cost incurred for such services.

Signed: _____ Date: _____

Mother Name: _____ Telephone: _____

Father Name: _____ Telephone: _____

ALTERNATE PERSON TO CALL FOR PICK UP IN CASE OF EMERGENCY

Name/relationship _____ Phone #: _____

Name/relationship _____ Phone #: _____

BASIC IMMUNIZATION SCHEDULE

	1 st visit@ 2 mo.	2 nd visit @4 mo.	3 rd visit@ 6 mo.	4 th visit @ 12 mo.	5 th visit @ 18 mo.	5-6 yrs.	Grade 6
Enter Date given							
Diphtheria	*	*	*		*	*	
Pertussis	*	*	*		*	*	
Tetanus	*	*	*		*	*	
Poliomyelitis	*	*	*		*	*	
Hib	*	*	*		*		
Measles				*	*		
Mumps				*	*		
Rubella				*	*		
Hepatitis B							***
Varicella (chicken pox)				*		* If not vaccinated or had disease	

Personal Health #: _____

Family Doctor: _____ Phone #: _____

Family Dentist: _____ Phone: _____

Information supplied on this form is for the custody and control of the care facility. Collecting such information is required by the Child Care Licensing Regulations.

General Information

OTHER CHILDREN LIVING AT HOME

Name: _____ Age: _____

Name: _____ Age: _____

Has your child been through any life changes that may affect his/her behavior here during Out of School Care?

Has your child had previous experience away from home?
(Day care, preschool, Sunday school Etc.) _____ Yes _____ No

If so Where? _____

Were there any special problems?

SPECIAL COMMENTS OR INSTRUCTIONS FOR CARE GIVER

(check all that apply)

___ On special medication ___ Allergies ___ Vision or hearing problems

___ Food dislikes ___ Special eating habits ___ other (please specify)

___ Special diet (for reasons of health, religion, ethnicity)

Give comments regarding those items checked

If your child is on any type of medication (Asthma Inhalers or Epi-Pens) licensing requires us to have Medication Agreements and Emergency Care Plans in place. Please ask the OSC Coordinator for these forms for your child's file.

PAYMENT AGREEMENT

Thank you for enrolling your child in the Oaklands OSC program. The program runs from September to June on a monthly basis. Pro-D days (unless pre-registered with monthly fees), early dismissal, Winter or Spring Break camps are not included in the fees and are separate registration. Fees are the same for each month of the year, regardless of the number of days care is provided or you choose to utilize. We do not offer part time or shared spaces in our Out-of-School Care program

Fees are the same amount for each month regardless of the number of days in a month. The monthly fee is determined using the average number of school days in a year divided by the number of months the school is in operation. For Families who decide to pay for Professional Development Days with their monthly fees these are fees calculated by number of Pro-D days in the school year divided by number of months school is in operation.

Your child's enrollment is confirmed as long as the following polices are adhered to:

1. Fees are due at the first program day of the month by posted dated cheque or direct debit withdraw. Failure to comply may result in your child being withdrawn from the program.
2. For parents who receive subsidy, it is your responsibility to ensure that your authorization is current and correct. Please note the date of your expiry and make your appointment to renew well in advance. Should you not renew you will be responsible for the complete payment of fees.
3. Our **cancellation policy** is as follows: 30 days cancellation - families are required to provide notice in writing by the 1st day of the month prior to leaving. Failure to do so will result in fees being charged
4. NSF fees are \$25 for any cheque or Direct Deposit payment returned as Nonsufficient Funds or Account Closed.

I have read and understand the above policies.

Signature: _____ Date: _____

Paying by Direct Debit

Paying by Post-Dated Cheques

All policies and procedures are outlined in the Out-of-School Care Program Handbook which all families will be given at time of registration.



Oaklands Community Association

Please complete the Pre-Authorized Debit (Direct Debit) agreement below.

1. Customer Information

Name: _____

Address: _____

City: _____ Province: _____

Phone No.: _____ Type of Service: Personal
Business

2. Bank Account Information (Please attach VOID cheque or Financial Institution Forms)

Financial Institution: _____

Branch Address: _____

Account #: _____ Transit #: _____
(branch – 5 digits; financial institution – 3 digits)

3. Pre-Authorized Debit (Direct Debit) Details

You, the Payor, authorize Oaklands Community Association to debit the bank account above on the first day is every month or the next business day, for regular monthly recurring and /or additional one time payments.

You, the Payor, are responsible for Non-Sufficient Funds (NSF) charges at \$25 per occasion in accordance with charges incurred by Oaklands Community Association.

You, the Payor, may revoke your authorization at any time by providing at least 10 days written notice. To obtain a sample cancellation form, or for more information on your right to cancel a Pre-Authorized Debit agreement, contact your financial institution or visit www.cdnpay.ca.

Signature of Account Holder

Signature of Joint Account Holder (if applicable)

Printed Name

Printed Name

You have certain rights if any debit does not comply with this agreement. For example, you have the right to receive reimbursement for any debit that is not authorized or is not consistent with this agreement. To obtain more information on your recourse rights, contact your financial institution or visit www.cdnpay.ca

OUT TRIP PERMISSION

I, _____ give permission to the staff of the Oaklands Community Association's Out of School Care Program, to take my child _____ on out trips or field trips that would require him or her to be away from the Oaklands Community Centre.

(Parent/Guardian Signature)

(Date)

SWIMMING PERMISSION

I, _____, give permission to the staff of the Oaklands Community Association's Out of School Care Program, to take my child _____ to swim in lifeguarded pools and lakes. My child is a:

____ Strong swimmer (deep water no problem/deep pool)

____ Capable swimmer (up to shoulder/shallow end on big pool)

____ Weak swimmer (waist deep/shallow end of big pool)

____ Non-swimmer (shallow water/small pool only)

Signature: _____

Date: _____

PHOTO PERMISSION

I, _____, give the Oaklands Out of School Care staff permission to take photos of my child, _____. It is my understanding that these pictures will only be used in the centre to represent the Out of School Care Program.

Signature: _____

Date: _____