

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: _____

Parent #1 Name: _____ Telephone: _____

Parent #2 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.
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 or Clinic: _____ Phone #: _____

Family Dentist or Clinic: _____ 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 their 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, Winter and 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.

Your child's enrollment is confirmed as long as the following policies 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

Pro D Day Separate Registration

Option One Single Days		Option Two All 7 Days
Sept 18 Monday	<input type="checkbox"/> \$45	\$280 \$35 savings
Oct 20 Friday	<input type="checkbox"/> \$45	
Nov 24 Friday	<input type="checkbox"/> \$45	
Feb 23 Friday	<input type="checkbox"/> \$45	
April 20 Friday	<input type="checkbox"/> \$45	
May 18 Friday	<input type="checkbox"/> \$45	
School Chosen Date Unknown	<input type="checkbox"/> \$45	
Total Amount Due with First Month Fees \$ _____		Once registered for Pro D Days there will be no refunds available regardless of attendance, unless family cancels their monthly OSC care.



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 of 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)

(Parent/Guardian 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 may be used to represent the Oaklands Community Association.

____ In-House Newsletters

____ Oaklands Community Association Promotional Material, including but not limited to the Activity Guide, Oaklands website, E-News and Social Media

(Parent/Guardian Signature)

(Date)