

**Medicine Hat Catholic Board of Education
St. Patrick's School
Out of School Care Program Registration Form**

For Office Use Only

- Deposit
- First month cheque/cash
- Signed up for Cash Online

STUDENT/FAMILY INFORMATION:

Legal Name: _____
(Last Name) (First Name) (Middle Name)
Street/Mailing Address (Legal land description if a P/O Box): _____
City: _____ Postal Code: _____ Home Phone: _____
Date of Birth: _____ Child's Age as of September 1st: _____ Gender: _____
(Year/Month/Day)

Parent / Guardian	Parent / Guardian
<p>Contact 1 Does child reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No Relationship to child: _____ Name: _____ Address (Legal land description if a P/O Box): _____ City: _____ Prov.: _____ Postal Code: _____ Contact Numbers: Home: _____ Work: _____ Cell: _____</p>	<p>Contact 2 Does child reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No Relationship to child: _____ Name: _____ Address (Legal land description if a P/O Box): _____ City: _____ Prov.: _____ Postal Code: _____ Contact Numbers: Home: _____ Work: _____ Cell: _____</p>

MEDICAL INFORMATION:

Family Physician: _____ Phone Number: _____
Does your child have any allergies? Yes No (If you indicated yes, please explain and include severity):

Are your child's immunizations up to date? Yes No
Does your child use any medication regularly? Yes No (If you indicated yes, please explain in detail):

EMERGENCY CONTACT INFORMATION:

In the event that a Parent/Guardian cannot be contacted, please list two alternate Emergency Contact persons:

Emergency Contact #1	Emergency Contact #2
Name: _____	Name: _____
Relationship to child: _____	Relationship to child: _____
Address: (Legal land description if a P/O Box) _____	Address: (Legal land description if a P/O Box) _____
City: _____ Prov.: _____	City: _____ Prov.: _____
Postal Code: _____	Postal Code: _____
Contact Numbers:	Contact Numbers:
Home: _____	Home: _____
Work: _____	Work: _____
Cell: _____	Cell: _____

DESIGNATED PICK-UP PERSON INFORMATION:

Person(s) other than Parent/Guardian or Emergency Contact authorized to PICK-UP child:

Pick-Up Person #1	Pick-Up Person #2
Name: _____	Name: _____
Relationship to child: _____	Relationship to child: _____
Contact Phone: _____	Contact Phone: _____

CUSTODY INFORMATION:

Please indicate whether a Parenting Order or Contact Order exists for your child. Yes No
***(If you indicated yes, legal documentation is required).**

FIRST-AID CONSENT:

I _____ give my permission to the Out of School Care staff at St. Patrick's School
(Print Name)
to administer medical attention in the nature of first-aid to my son/daughter _____
in the event of an emergency. (Print Child's Name)
Signature: _____ Date: _____

MEDICINE HAT CATHOLIC BOARD OF EDUCATION OUT OF SCHOOL CARE PROGRAM PARENT AGREEMENT:

1. Medicine Hat Catholic Board of Education Out of School Care Programs assume no liability or responsibility for anything that occurs because of false information provided at the time of registration. It is the parents' responsibility to inform the Out of School Care Program Coordinator of any changes that occur after the original registration form was completed. (i.e., phone number, employment, emergency pick up, etc.).
2. Parents or designate must physically accompany their child into the designated program area for all drop-offs and pick-ups, ensuring their child is signed in and out of the program. Children will be released only to authorized persons as stated by the parents or guardians on the registration form. Children WILL NOT be released to anyone not on the registration form.
3. Parents requiring scheduled care agree to provide the hours of care required to the Out of School Care Program Coordinator as soon as possible. Parents are responsible for adhering to this schedule and will advise the Out of School Care Program Coordinator of any changes to arrival and pickup times.
4. In the event of a serious medical emergency, the supervisor will call 911 and then contact the parents or guardians. If a child is ill, the parent(s) or guardian(s) will be contacted and must pick up the child immediately. The Out of School Care Program reserves the right to engage emergency medical assistance for any child left in its care, when such assistance is deemed to be necessary. The expense of the required assistance to be borne solely by the parents or guardians of the child.
5. The parents agree to pay according to the attached fee schedule. Please note fees are subject to change. Service will be cancelled for those who fail to pay.
6. One month written notice must be submitted to the Out of School Care Program Coordinator to terminate your child's involvement in the program. A one month fee will be charged to any parents who fail to provide notice.
7. The program will not operate on school holidays, which include Christmas break, Easter break, and Professional Development days, including teacher's convention.

I have seen, read and agree with the above outlining my responsibilities to the MHCBE Out of School Care Program.

We, the undersigned being the parents and/or legal guardians of _____ (name of child) hereby certify that we have given careful consideration to the participation by our son/daughter in the MHCBE Out of School Care Program and understand fully the nature and character of the risk undertaken by our son/daughter and agree to accept on behalf of the same child, all risks and responsibilities for injury or damage beyond the control of the MHCBE Out of School Care School Program. We further certify, we are hereby releasing the MHCBE Out of School Care School Program, School Administration, and the Medicine Hat Catholic Board of Education and their sub-agents from all claims and demands whatsoever, occurring as a result of damage incurred to the child by reason of activities outside of the authority extended by the MHCBE Out of School Care School Program in the conduct of this project. I consent to the MHCBE Out of School Care School Program sharing information with teachers and staff of the School as needed about my child.

Parent/Guardian #1 Signature

Date

Parent/Guardian #2 Signature

Date

Out of School Care Representative Signature

Date

Start Date: _____

Applying for Provincial Subsidy: Yes No

Fee Schedule: \$1.00 for every 15 minutes

- The time of charge is rounded to the nearest 15 minute interval within the hour as the child enters the OSC program.
- All students remain in the gym until the first bell of school (8:55 am).
- Fees are subject to change with 2 months' notice and communication provided to parents.