



**Out-of-School Care Registration Form
2010-2011**

Out-Of-School Care	Place a check mark beside your child's school	Type of Care Required	Place a check mark beside your choice of care
Fairfield		Before School Care	
Margaret Jenkins		Afterschool Care Only	
Sundance		Before & Afterschool	

FAMILY INFORMATION: PARENT(S)/GUARDIAN(S) WITH LEGAL CUSTODY

Child's Name: _____ Entering Grade: _____

Date of Birth: (MM/DD/YY) _____ Gender: _____

Parent/Guardian: _____ Home #: _____ Cell: _____

Home Address: _____ Postal Code: _____

E-mail: _____

Place of Work: _____ Hours of Work: _____ Work #: _____

Parent/Guardian: _____ Home #: _____ Cell: _____

Home Address: _____ Postal Code: _____

E-mail: _____

Place of Work: _____ Hours of Work: _____ Work #: _____

NOTIFICATION:

Which parent/guardian will be the main contact for administrative purposes?

Name: _____ E-mail Address: _____

PERSONS NOT PERMITTED ACCESS TO THE CHILD:

Are there custody orders? ___ Yes ___ No If yes, attach documentation

Name: _____ Relationship to Child: _____

PAYMENT AND TAX RECEIPT:

Do you require a split tax receipt? Yes No

If yes, please list the parent(s)/guardian(s) who will receive tax receipt and in what percentage?

Parent/Guardian: _____ Percentage: _____

Parent/Guardian: _____ Percentage: _____

If no, who will be the primary recipient of the tax receipt? _____

Do you require a split payment with another parent/guardian? YES NO

Parent/Guardian: _____ Percentage of Payment: _____

Parent/Guardian: _____ Percentage of Payment: _____

LOCAL EMERGENCY CONTACTS:

A minimum of three persons, other than parents/guardians, who are authorized for pick up

Name: _____ Relationship to family: _____

Phone#: _____ Work #: _____ Cell #: _____

Name: _____ Relationship to family: _____

Phone#: _____ Work #: _____ Cell #: _____

Name: _____ Relationship to family: _____

Phone#: _____ Work #: _____ Cell #: _____

CONFIDENTIAL MEDICAL & PERSONAL INFORMATION:

Practitioners	Name	Phone #	Address
Family Doctor			
Family Dentist			
Medical Health Number			

I have attached a photocopy of my child's immunization record.

We choose not to immunize our child. _____

Signature of Parent/Guardian

COMMENTS OR INSTRUCTIONS FOR CAREGIVER:

Comments: Food Dislikes, Special Eating Habits and or Vision/Hearing Problems

Medication: _____ Allergies: _____

Special Instructions from Parent or Health Care Professionals and or a Care Plan

Indicate Behavioral, Medical Disabilities or Illnesses your child may have:

Major changes child has experienced (i.e. divorce, separation, recently moved, death in the family):

Child's swimming experience: Please circle

Has your child had lessons? Yes No

Level completed: _____

My child must wear a life jacket at all times: Yes No

My child must wear a life jacket in the deep end only: Yes No

Permission to go in the deep end: Yes No

Comments: _____

(For your child's safety, they will be asked to complete a swim test by pool staff)

Photo Requirement and Photo Release

The FGCA considers the safety of your child its main priority. We are required by VIHA to have your child's photo on file. The emergency card document is for internal and medical use only. Please fill in the form below with your initials in the appropriate column indicating your approval.

I, _____, the parent/guardian of _____, advise the FGCA of the following:

	YES	NO
I permit the FGCA to photograph my child(ren) for arts and crafts.		
I permit the FGCA to photograph my child(ren) for our agency publication "The Moss Rock Review"		
I permit the FGCA to photograph my child(ren) for promotional use in the community active living guide.		
I permit the FGCA to photograph my child(ren) for display on the FGCA website.		
I permit the FGCA to photograph my child(ren) for display in the FGCA only.		