



APPLICATION FORM
YEAR 2010-2011
AFTER SCHOOL CARE PROGRAM

Child's name: _____ **First name:** _____

Birth date: _____

Mother's name: _____

Address : _____ **Postal code:** _____

Mother's work: _____ **Address:** _____

Cell. Phone : _____ **Home phone:** _____ **Work phone:** _____

e mail : _____ @ _____

Father's name: _____

Address : _____ **Postal code:** _____

Father's work: _____ **Address:** _____

Cell. Phone: _____ **Home phone:** _____ **Work phone:** _____

e mail : _____ @ _____

First name and age of the brothers and sisters:

1 _____

3 _____

2 _____

4 _____

Name of the person to be called if the parent cannot be reached:

1 _____ relationship _____

Address : _____ **Phone:** _____

2 _____ relationship _____

Address : _____ **Phone:** _____

Date :

Signature of parent or guardian:



MEDICAL FORM 2010-2011

IDENTIFICATION

Name : _____ Surname : _____

D.O.B : _____

Full name of the parent to reach : _____

Cell. Phone : _____ Home phone: _____ Work phone: _____

CHILD'S HEALTH

Physician's name: _____ Address: _____

Phone : _____

OTHER

Previous communicable diseases: _____

Previous illness or injury: _____

Special medical information or allergies: _____

Medication administered regularly: _____

Special diet: _____

Please comment on your child's development giving information that would be useful to the program in the provision of care (eg. habits, fears, favorite activities, routines, etc.)

In case of an accident or illness, the personnel of the *Une École Pour Tous LTÉE* will administer first aid, ensuring that the child receives the emergency care required and that the parents are notified as soon as possible.

Any transportation fees, in case of emergency, will be charged to the parents.

Mr or Mrs _____ authorizes *Une École Pour Tous LTÉE* to transmit this information to the people concerned.

YES

NO

Please attach a copy of your child's record of immunization or immunization exemptions

Date:

Signature of parent or guardian:

