

P.O.O.S.C.A.

(PARKDALE OUT OF SCHOOL CARE ASSOCIATION 1991)

THE NEXT BEST PLACE TO HOME

North Glenmore Park Community Assoc.

2231 Longridge Dr., SW.

Tel: Program- 403-714-1410 or Dianne - 403-999-4616

E-Mail: pooscacqs@gmail.com

PERSONAL AND CONFIDENTIAL
(Please complete all areas)

START DATE: / /
 D M Y

NAME: _____

DATE OF BIRTH: / / SCHOOL _____ GRADE: _____
 D M Y

CHILD'S ADDRESS: _____

MOTHER'S NAME: _____ (Cell) _____

ADDRESS: _____ TELEPHONE: (H) _____ (B) _____

E-MAIL: _____ POSTAL CODE: _____

FATHER'S NAME: _____ (Cell) _____

ADDRESS: _____ TELEPHONE: (H) _____ (B) _____

E-MAIL: _____ POSTAL CODE: _____

DAYS ATTENDING: M T W TH F START DATE: _____

TIMES ATTENDING: BEFORE: _____ / AFTER: _____

FULL TIME: _____ PART TIME: _____

PROFESSIONAL DAYS: YES: _____ NO: _____

PLEASE SPECIFY CHILD CARE IF NOT FULL TIME: _____

CHILD WILL BE PICKED UP BY: _____

CHILD NOT TO BE RELEASED TO: _____

ALTERNATE EMERGENCY CONTACTS AVAILABLE DURING PROGRAM HOURS:

NAME: _____ TELEPHONE: _____ ADDRESS: _____

COMMENTS?: (ANYTHING AFFECTING THE CARE OF YOUR CHILD) _____

ALBERTA HEALTH CARE NUMBER: _____

MEDICAL INFORMATION (ALLERGIES, ONGOING MEDICATION, ETC): _____

ARE ALL IMMUNIZATION RECORDS CURRENT? _____ YES _____ NO

Cultural or Ethnic family background _____

This will be helpful when we are doing Multi-cultural activities throughout the year

I would be willing to share my culture (artifacts, recipes, language info, etc) yes _____ no _____

CONSENT FOR MEDICAL ATTENTION:

I _____ HEREBY AUTHORIZE EMERGENCY CARE FOR _____
PARENT/GUARDIAN (PLEASE PRINT) CHILD'S NAME

PARENT'S SIGNATURE

TERMINATION DATE