Application Form

|  |  |  |  |
| --- | --- | --- | --- |
| SITE: |  | ID NUMBER: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| CLASS: | AM PM  NEW RETURNING | START DATE: |  |

*(Office Use Only)*

Child’s Information

|  |  |
| --- | --- |
| Legal Name: |  |

(first) (middle) (last)

|  |  |
| --- | --- |
| Other Known Names: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Birth: |  | Gender: | Male Female |

(Month/Day/Year)

|  |  |
| --- | --- |
| Address: |  |

|  |  |
| --- | --- |
| Is this the first time attending this program? |  |

|  |  |
| --- | --- |
| If no, date previously attended: |  |

(Month/Day/Year)

Aboriginal Learner Data Collection Initiative

It is mandatory that this question be included in registration form, however answering the question is not. Self-identification is voluntary and will not require documentation.

If you wish to declare that your child is an Aboriginal person, please specify:

|  |  |  |  |
| --- | --- | --- | --- |
|  | 331 Status Indian / First Nations |  | 333 Metis |
|  | 332 Non-Status Indian / First Nations |  | 334 Inuit |

Primary Caregiver Information

|  |  |
| --- | --- |
| Legal Name: |  |

(first) (middle) (last)

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Birth: |  | Gender: | Male Female |

(Month/Day/Year)

|  |  |
| --- | --- |
| Address: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Phone: | ( ) | Work: | ( ) | Cell: | ( ) |

|  |  |
| --- | --- |
| Email: |  |

|  |  |
| --- | --- |
| Relationship to Child:  (check one) | Mother Father Grandmother Grandfather  Aunt Uncle Sibling Foster Parent  Other : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (please specify) |

|  |  |
| --- | --- |
| How many times have you moved in last year? |  |

|  |  |
| --- | --- |
| Education Level: |  |

Additional Caregiver Information: (if any)

|  |  |
| --- | --- |
| Legal Name: |  |

|  |  |
| --- | --- |
| Address: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Phone: | ( ) | Work: | ( ) | Cell: | ( ) |

|  |  |
| --- | --- |
| Relationship to Child:  (check one) | Mother Father Grandmother Grandfather  Aunt Uncle Sibling Foster Parent  Other : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (please specify) |

Annual Family Income

Less than $ 12,000 $ 12,000 - $ 15,000 $ 15,001 - $ 18,000 $ 18,001 - $ 21,000

$ 21,001 - $ 24,000 $ 24,001 - $ 27,000 $ 27,001 - $ 30,000 $ 30,001 - $ 33,000

$ 33,001 - $ 36,000 $ 36,001 - $ 39,000 Over $ 39,000

Source of Income (check all that apply)

Employment Social Assistance Student Finance Child Support

Employment Insurance AISH/Disability Canada Pension Plan

WCB Child Tax

|  |  |
| --- | --- |
| Does your current income meet the financial needs of your family? | Yes No |

|  |  |
| --- | --- |
| Does your family have needs that are not being met? Yes No | |
| Explain: |  |

|  |  |
| --- | --- |
| How is this affecting your family? Yes No | |
| Explain: |  |

Have you been involved with any workshops or programs regarding:

|  |  |
| --- | --- |
| Parenting Techniques: |  |
| Anger Management: |  |
| Child Development: |  |
| Life Skills: |  |
| Aboriginal Cultural Practices: |  |
| Other: (please specify) |  |

|  |  |
| --- | --- |
| Do you practice traditional Aboriginal culture at home? |  |

Health Information

Does your child have any special needs which should be addressed? (special diet, language issues, particular fears etc.)

|  |
| --- |
|  |
|  |
|  |
|  |

Are there any family issues in your home that may be affecting your child that should be addressed?

|  |
| --- |
|  |
|  |
|  |
|  |

|  |  |
| --- | --- |
| Family Doctor: |  |
| Address: |  |
| Telephone: |  |

|  |  |
| --- | --- |
| Alberta Health Care #: |  |

|  |  |
| --- | --- |
| Status #: |  |

|  |  |
| --- | --- |
| Has your child been immunized? |  |

|  |
| --- |
| Does your child have any allergies? If so, please detail below. |

|  |  |  |
| --- | --- | --- |
| Allergy | Reaction | Treatment/Medication |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| Does your child have asthma? |  |

|  |  |
| --- | --- |
| If so, how is it treated? |  |

|  |  |
| --- | --- |
| Is your child on regular medication? |  |

|  |
| --- |
| Please provide details regarding medication (how it is administered, how often, any side effects etc.) |
|  |
|  |
|  |
|  |

Personal and Social Development

|  |  |
| --- | --- |
| What is the primary language of your child? |  |

|  |  |
| --- | --- |
| What is the secondary language of your child? |  |

|  |
| --- |
| How would you describe your child’s speech abilities? |

(check all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Sometimes |
| Easy to understand |  |  |  |
| Difficult to understand |  |  |  |
| Talkative |  |  |  |
| Stutter |  |  |  |
| Speaks in sentences (3 or more words) |  |  |  |
| Shy or Quiet |  |  |  |
| Outgoing or loud |  |  |  |

Transportation

Children registered in this program who live within the designated boundaries of each school are provided with transportation by licensed bus drivers.

|  |  |  |
| --- | --- | --- |
|  | AM Class | PM Class |
| Hours for Pick-up | 7:30 am – 8:15 am | 11:30 am – 12:45 pm |
| Hours for Drop-off | 11:30 am – 12:30 pm | 4:00 pm – 5:00 pm |

|  |  |
| --- | --- |
| Does your child require transportation? |  |

|  |  |  |
| --- | --- | --- |
| Pick-up/Drop-off Locations: | Home to Home | Daycare to Daycare |
| (please circle one) | Home to Daycare | Daycare to Home |

|  |  |
| --- | --- |
| Name of Daycare: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Contact Person: |  | Phone: | ( ) |

|  |  |
| --- | --- |
| Address: |  |

Community Resources and Services

|  |  |
| --- | --- |
| Are you presently involved with or accessing any resources from an agency? |  |

|  |  |
| --- | --- |
| Comments: |  |
|  |  |
|  |  |

|  |
| --- |
| Would you like to know about resources and services available to you and your family in your community? Yes No Maybe |

|  |
| --- |
| Do you need assistance contacting agencies or services that may be of help to your child and your family? Yes No Maybe |

|  |
| --- |
| What kind of resources and services would you be interested in hearing about or accessing? (check all that apply) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Transportation (low income bus pass) | |  | Housing Applications |
|  | Childcare Resources | |  | Counselling Services |
|  | Food Bank Referrals | |  | Fee Assistance Applications (recreation) |
|  | Other: |  | |  |

|  |
| --- |
| What are you hoping your child will gain from attending this program? (check all that apply) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | To learn about his/her culture & heritage | |  | To improve social interaction skills |
|  | To learn about his/her language | |  | To improve communication skills |
|  | To prepare for kindergarten | |  | To interact with others his/her age |
|  | Other: |  | |  |

|  |
| --- |
| What are you hoping this program will offer you as a caregiver? |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | To meet other parents | |  | To learn new parenting strategies |
|  | To learn about your culture/language | |  | To learn how to help your child learn |
|  | Other: |  | |  |

Emergency Contact/Alternate Pick-up Information

Contact #1

|  |  |
| --- | --- |
| Name: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Home Phone: | ( ) | Cell Phone: | ( ) |

|  |  |
| --- | --- |
| Address: |  |

|  |  |
| --- | --- |
| Relationship to Child: |  |

Contact #2

|  |  |
| --- | --- |
| Name: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Home Phone: | ( ) | Cell Phone: | ( ) |

|  |  |
| --- | --- |
| Address: |  |

|  |  |
| --- | --- |
| Relationship to Child: |  |

|  |  |
| --- | --- |
| Is any person denied access to your child? |  |

|  |  |  |
| --- | --- | --- |
| If so, please list their name(s) below: | |  |
| 1 |  |  |
| 2 |  |  |