Eagles Nest Little Eagles

REGISTRATION PACKAGE

My Child will be Attending Half Day_____ or Full Day_____

Child's Name: _____ Child's Preferred Name: _____

Date of Birth: _____ Gender: M: ___ F: ___ Health Care Number:_____

Resides with: Both Parents: ___ Mom: ___ Dad: ___ Other: ___ (please specify):_____

Mother's Name: _____ Father's Name: _____

Mother's Address: _____ Father's Address: _____

Legal Land Location: _____ Legal Land Location: _____

(Must be provided if you don't have a street address)

Mother's Home Phone: _____ Father's Home Phone: _____

Mother's Cell Phone: _____ Father's Cell Phone: _____

Mother's Work Phone: _____ Father's Work Phone: _____

Mother's Email: _____Father's Email:_____

1. PLEASE LIST AN EMERGENCY CONTACT IN THE CASE THAT THE PARENTS CANNOT BE REACHED:

Name: _____ Home Phone: _____

Cell Phone: _____ Address: _____

OR Legal Land Location: _____

(Must be provided if you don't have a street address)

Relationship to Child: _____

2. LIST ANYONE NOT LEGALLY ALLOWED ACCESS TO YOUR CHILD

(IE: CUSTODY AGREEMENTS)

Name: _____ Relationship to Child: _____

3. LIST OTHER PEOPLE AUTHORIZED TO PICK UP YOUR CHILD

(OTHER THAN PARENTS)

Name: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____

Name: _____ Relationship to Child: _____

Home Phone: _____ Cell Phone: _____

4. LIST ANY ALLERGIES THAT YOUR CHILD HAS: _____

(Please fill out the **Allergy Instructions Form** in this package)

5. LIST ANY MEDICAL CONDITIONS THAT YOUR CHILD HAS: _____

_____

(Please fill out the **Medical Treatment Release Form** in this package)

6. PARENT ORIENTATION

Before your child is registered with our program you must read and be familiar with the Parent Handbook. Please return this package along with your deposit and **check the box below:**

☐ **I have read the parent handbook and am familiar with all Eagles Nest policies**

Signature: _____ **Date:** _____

Revised: August, 2020

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HEALTH RECORD

Child's Physician: _____ Address: _____

Physician's Phone #: _____

Are your child's immunizations up to date? Yes: ___ No: ___

EMERGENCY MEDICAL TREATMENT

I/We, _____, give consent to the staff of Eagles Nest Before and After School Care to provide or allow for medical treatment to be given to my child.

I/We understand that if an emergency should occur, the Program will make every effort to contact me (parents or guardians). Should they be unsuccessful, I authorize any and all employees of Eagles Nest to sign for medical treatment for my child, including transportation by an ambulance if necessary.

Signature: _____ **Date:** _____

FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT

I/We, give permission to share necessary personal information (name, phone number) with other staff and parents for the purpose of program coordination.

Signature: _____ **Date:** _____

PHOTO PERMISSION

I, give permission for my child's photograph to be taken and released in any medium (Facebook, website, etc.)

Signature: _____ **Date:** _____

ALLERGY INSTRUCTIONS

Child's Name: _____

My child is allergic to: _____

This allergy is: Mild: ___ Moderate: ___ Severe: ___

Please explain your child's symptoms: _____

_____

_____

I entrust Eagles Nest Staff to do the following upon an allergic reaction (Please specify steps):

_____

_____

Signature: _____ **Date:** _____

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MEDICAL TREATMENT INSTRUCTIONS AND RELEASE

Child's Name: _____

Child's Medical Condition: _____

What triggers the condition?

_____

_____

Does your child need medication administered ? Yes: ___ No: ___

(You must fill out an Individual **Medication Record** for your child if medication needs to be administered) Eagles Nest Staff will administer antidote/allergy/seizure medication on an emergency basis.

Should a life-threatening emergency occur, is there any medical treatment that you would not wish your child to have? (Please explain):

_____

_____

I understand that it is my responsibility to inform Eagles Nest staff if there are any changes to the above information.

Signature: _____ **Date:** _____

PARENT HELPER

I understand that many jobs and/or life commitments just don't provide parents with the freedom to spend time in the classroom. However, if your days are somewhat flexible and you are brave enough to give us a little time, we would love to have you!

Yes: ___ No: ____ Signature: _____

"Parent Helpers" will assist the teacher with crafts, snack time, fieldtrips, and assist with the children as needed. (Eg: Washroom Routines) We encourage parent participation with children in creative areas, such as music, story-telling etc.

Please do not bring older or younger siblings during your Parent Helper class.

FIELD TRIPS

Throughout the year we will take many field trips within the Village of Edgerton (Downtown Playground, Skating Rink, and The Village Library on the LAST Tuesday of every month. These fieldtrips are always done by walking and are accompanied by the Teacher and Parent Helper.

I/We, _____ give permission for my child _____ to participate in the above-mentioned fieldtrips.

Signature: _____ **Date:** _____