OSCAR Yearly Registration

Parent Information: Who does the program staff contact first and second?

1st
Parent Contact ____________________
Last First

Legal Land Address: ____________________

Mailing Address: ____________________

City: ____________ Postal Code__________

Home Phone: ____________________

Cell Phone: ____________________

Place of Work: ____________________

Work Phone: ____________________

2nd
Parent Contact ____________________
Last First

Legal Land Address: ____________________

Mailing Address: ____________________

City: ____________ Postal Code__________

Home Phone: ____________________

Cell Phone: ____________________

Place of Work: ____________________

Work Phone: ____________________

PLEASE LIST *LOCAL* EMERGENCY CONTACT IF THE PARENTS CANNOT BE REACHED:

Required
Emergency Contact____________________

Relationship to child: ____________________

Legal Land Address: ____________________

Home Phone: ____________________

Cell Phone: ____________________

Work Phone: ____________________

List all names with first & last of which **you authorize to pick up your child/ren.** Include phone numbers if you wish
(Parents and emergency contact are already authorized to pick up)

____

____

____

____

Name anyone **NOT allowed access** to your child and relationship to your child. Provide Court Order if applicable.

____

EMERGENCY CONSENT: I/We understand that if an emergency should occur, OSCAR will make every effort to contact me/us, the parent/guardian. Should they be unsuccessful in locating me/us, I/we authorize any and all employees of the OSCAR program to sign for medical treatment of my/our child, including transportation by ambulance (cost to parent) if deemed necessary. I/We also give permission to the attending physician to treat my/our child/ren for illness or injury as is necessary under these circumstances. This release form will be in effect from the date below until termination of enrolment or current school year.

Parent/Guardian Signature (any format) ____________________ Date ____________

Witness: ____________________ Date ____________
(Other than immediate family) (any format)

*Should a life-threatening emergency occur is there any medical treatment that you would not wish your child/ren to have?

____

____

Information collected on these forms is subject to the Freedom of Information and Protection of Privacy Act.
The information will be used solely for the purpose of OSCAR Out-of-School Care Program. For more information contact 780-672-0141.

ACKNOWLEDGEMENT, CONSENT & PERMISSION

PRINT Name of Child or Children ____

I/We____________________________________ agree to the following as initialed below:
PRINT (Parent /Guardian full name)

Must initial all 6.

____: **FREEDOM OF INFORMATION & PROTECTION OF PRIVACY ACT**
Understand that the information collected on these forms is for the sole purposes of the OSCAR Program

____: **OSCAR PROGRAM FEES**
Have read and agree to the OSCAR Program fees. (Also listed on web site: www.camrosefcss.ca)

____: **OSCAR POLICY**
Have read and agree to follow the OSCAR policies. (Available on web site: www.camrosefcss.ca)
Agree to contact the director immediately with concerns at the program and abstain from posting on social media, or recording by voice or video while at the program without the expressed written consent of the Director. Failure to follow will result in dismissal from the program.

____: **DISCIPLINE POLICY**
Have read and agreed with the Discipline Policy of the OSCAR Program. (Policy Manual & Parent Handbook)

____: **OSCAR/SCHOOL SHARING PERMISSION**
Authorize OSCAR Child Care and my child's School to share Child Specific Information with each other that is in the best interest of my child or children according to the Communication Policy in the Policy Manual. (Allow OSCAR to talk with the school about your child or children specific to what is happening)

____: **Off-Site Activity PERMISSION**
Authorize OSCAR Child Care take my child to licensed approved areas on the school property.

Initial only one option!

____: **PHOTO PERMISSION** - NO public release – crafts, activities & displays only
Authorize OSCAR Child Care to take pictures of my child or children to display in the school, OSCAR photo album and for crafts and activities. Photos will not appear on our program website or newsletters.

____: **NO PHOTO PERMISSION**
DO NOT authorize OSCAR Child Care to take pictures of my child or children.
If your child happens to be in the picture, your child's face will be covered.

Initial only one option!

CHOOSE YOUR RATE!

____: **$7.00 Hourly Rate**
I choose the hourly rate and agree the hour starts at school dismissal time, and every hour after while my child is at the program.

____: **$15.50 Day Rate**
I choose the day rate and agree this starts at school dismissal and will pick up before 6:00 each day my child is at the program.

SIGNATURE any format: ____________________________ DATE: ______________

Email Address: ____________________________

For Invoices, Newsletter & Reminders (Please print clearly)

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1st
CHILD'S NAME________________________________ **SCHOOL:** ____________________ **Grade:** ____
Last First

Child's Address: ____ Alberta Health Care No. ______________________________

DATE OF BIRTH: **Month** ______________ **Day** ________ Year ________ Child's Physician/Clinic: ______________________________

Gender: **Male** or **Female** Physician Office Phone: ______________________________

Is your child's immunization up to date? **Yes** or **No** Has your child previously attended OSCAR? **YES** or **NO**

If immunization not up to date state reason: ____

Are there any **special circumstances or information** we should be aware of that would help us work with your child? __________

____

____

____

Medical History of Illness: Please describe your child's former or current medical history and any medication they currently take.

____

____

____

Medication Instruction Form Required: **If your child does have an Epi-Pen or Asthma Inhaler medication and would require medication during his/her time at OSCAR please fill out the Medication Instruction Form** (all medication MUST be in Original Labeled Container) and discuss the specifics with the OSCAR Director. OSCAR staff can only administer medications according to the instructions.

ALLERGIES

Does your child have any allergies to the following?

Foods: ____

Other: ____

Medication Allery: ____

ASTHMA

Does your child have Asthma? YES or NO

Specify Triggers: ______________________________

Location of Inhaler: ______________________________

Medication Form: YES or NO

Epi-Pen

Does your child require an Epi-Pen? YES or NO

Specify Allergy: ______________________________

Location of Epi-Pen: ______________________________

Medication Form: YES or No

Allergy Treatment: ____

____

I understand that it is my responsibility to update and inform the OSCAR Child Care Director if there are any changes to **any** of the above address/information/directions/condition for my child named above.

______________________________________ ______________________________

Parent/Guardian Signature (any format) **Date**

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2nd
CHILD'S NAME________________________________ **SCHOOL:** ____________________**Grade:** _____
Last First

Child's Address: ______________________________________ Alberta Health Care No. ____________________________

DATE OF BIRTH: **Month** **Day** Year Child's Physician/Clinic: ______________________________

Gender: **Male** or **Female** Physician Office Phone: ______________________________

Is your child's immunization up to date? **Yes** or **No** Has your child previously attended OSCAR? **YES** or **NO**

If immunization not up to date state reason: ____

Are there any **special circumstances or information** we should be aware of that would help us work with your child? __________

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Does your child have any allergies to the following?

Foods: ____

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Medication Allergy: ____

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Does your child have Asthma? YES or NO

Specify Triggers: ____________________________________

Location of Inhaler: __________________________________

Medication Form: YES or NO

Epi-Pen

Does your child require an Epi-Pen? YES or NO

Specify Allergy: ____________________________________

Location of Epi-Pen: __________________________________

Medication Form: YES or NO

Allergy Treatment: ____

____

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____________________________________ ______________________________
Parent/Guardian Signature (any format) **Date**

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