Holy Cross School

300 Dubuc Street, Winnipeg, MB, R2H 1E4
Voice (204) 237-4936, Fax (204) 237-7433
Principal acap@holycrossschool.mb.ca
www.holycrossschool.mb.ca

Student Registration Form

2018-2019

Return completed Registration Form to the school office, along with the non-refundable registration fee of $75.00

Application for Grade: _____

Application for Kindergarten: ___ ☐ ___ Full Days
PreK Program (age 4) _____ Full Days

For Office Use Only

Date received _____

Fees paid: Registration fee $_____ ☐

Class fees $_____ ☐

Fundraising Supplement $_____ ☐

Tuition $_____ ☐

Student's Legal Name: _____ _____ _____
(As it appears on Birth Certificate) Last First Middle

EMAIL ADDRESS PLEASE _____
to send out newsletters electronically.

Student's Address: _____
Apt. Number, Street number, Street name, City, Province, Postal Code

Home Phone Number: _____ Birth date: _____ _____ _____
Year Month Day

Gender: ☐ Male ☐ Female Home School Division: _____

Current School and address: _____

Canadian Citizen: ☐ Yes ☐ No Landed Immigrant: ☐ Yes ☐ No (if yes, attach documentation)

Religion: _____ Parish: _____

Year of: Baptism _____ Confirmation _____ First Communion _____

Name of Person(s) with whom the student resides: _____
Relationship to student:

☐ Parent ☐ Mother ☐ Father ☐ Guardian ☐ Foster ☐ Stepfather ☐ Stepmother ☐ Other_____

Custody: ☐ Not applicable **OR** ☐ Joint **OR** Exclusive: ☐ Mother ☐ Father ☐ Guardian

Are there any custody restrictions? ☐ Yes ☐ No If yes, please describe _____

_____

If there are custody restrictions, it is the parent/guardian's responsibility to inform the school.

Aboriginal Ancestry Please check one of the following to indicate student's ancestry:
This information is required for reporting to the Provincial Government.

☐ Métis/Mixed Ancestry ☐ Non-Status ☐ Treaty/Status ☐ Aboriginal

Student's previous last name (if applicable): _____
Language(s) spoken: _____

Can you assist with volunteer duties for the school such as helping with evening Bingos, sporting events, parent advisory committee, spring tea, costumes for Advent, graduation, etc. YES____ NO_____.

FATHER/GUARDIAN	MOTHER/GUARDIAN
Full name: _____	Full name: _____
Address: _____	Address: _____
Email:_____	**Email:**_____
Home phone: _____	Home phone: _____
Employer: _____	Employer: _____
Occupation: _____	Occupation: _____
Business phone: _____	Business phone: _____
Cell phone: _____	Cell phone: _____

Applicant's siblings:

Name	Age	School or occupation

EMERGENCY CONTACTS

Name	Relationship to student	Home Phone Number	Business phone number

MEDICAL INFORMATION

Manitoba Health Registration Number:_____ PHIN: _____
6 digits 9 digits

Family Doctor: _____ Phone number: _____

It is important that we are aware of any medical condition and ongoing prescribed medication.

Is the student on any ongoing prescribed medication? ☐Yes ☐ No General Health:_____
Name of medication(s): _____

Who administers the medication during school hours? ☐ Home ☐ School ☐ Child (self-administered)

Does the student require any special medical procedures to be monitored or carried out by the school? ☐Yes ☐No
Other medical condition(s)/allergy(ies) that may affect student's adjustment and performance:_____
_____

All parents are members of our Parents' Advisory Committee (PAC). If you do not wish to have your name and telephone number given to the PAC, please check the following box: ☐ No

I have read the uniform policy and will abide by all the sections of the uniform policy.

It is the responsibility of the parent/guardian to advise the school of any changes in the information recorded here.

Signing this registration form gives Holy Cross School permission to use your child's picture in promotional advertising, on the web or for school events. Please submit a request in writing to the office should you NOT want your child's picture used for these purposes.

_____ _____ _____
Date Father's Signature Mother's Signature

This personal information is being collected to School Board Policy and will be used for the purpose of maintaining accurate and detailed records for as long as it serves the educational needs of the student. It is protected by the Protection of Privacy provisions of the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection, contact the school principal at Holy Cross School.

Unified Referral and Intake System (URIS) Group B Application

In accordance with Section 15 of *The Personal Health Information Act* (PHIA), the purpose of this form is to identify the child's health care intervention(s) and apply for URIS Group B support which includes the development of a health care plan and training of community program staff by a registered nurse. If you have questions about the information requested on this form, you may contact the community program.

Section I – Community program information (to be completed by the community program)

Type of community program (please √)	Name of community program: HOLY CROSS SCHOOL
❑ School ❑ Licensed child care ❑ Respite ❑ Recreation program	Contact person: Resource
	Phone: 204-237-4936 Fax: 204-237-7433
	Email: secretary@holycrossschool.mb.ca
	Address : Holy Cross School Street: 300 Dubuc Street City/Town: Winnipeg, Manitoba POSTAL CODE: R2H 1E4

Section II - Child information

Last Name **First Name** **Birthdate**

Also Known As

month (print) D D Y Y Y Y

Please check (√) all health care conditions for which the child requires an intervention during attendance at the community program.

❑ **Life-threatening allergy (and child is prescribed an EpiPen)**

Does the child bring an EpiPen to the community program? ☐ YES ☐ NO

❑ **Asthma (administration of medication by inhalation)**

Does the child bring asthma medication (puffer) to the community program? ☐ YES ☐ NO

Can the child take the asthma medication (puffer) on his/her own? ☐ YES ☐ NO

❑ **Seizure disorder**

What type of seizure(s) does the child have? _____

Does the child require administration of rescue medication (e.g., sublingual lorazepam)? ☐ YES ☐ NO

❑ **Diabetes**

What type of diabetes does the child have? ☐ Type 1 ☐ Type 2

Does the child require blood glucose monitoring at the community program? ☐ YES ☐ NO

Does the child require assistance with blood glucose monitoring? ☐ YES ☐ NO

Does the child have low blood sugar emergencies that require a response? ☐ YES ☐ NO

❑ **Cardiac condition** where the child requires a specialized emergency response at the community program.

What type of cardiac condition has the child been diagnosed with? _____

❑ **Bleeding Disorder** (e.g., von Willebrand disease, hemophilia)

What type of bleeding disorder has the child been diagnosed with? _____

❑ **Steroid Dependence** (e.g., congenital adrenal hyperplasia, hypopituitarism, Addison's disease)

What type of steroid dependence has the child been diagnosed with? _____

❑ **Osteogenesis Imperfecta (brittle bone disease)**

❑ **Gastrostomy Feeding Care**

Does the child require gastrostomy tube feeding at the community program? ☐ YES ☐ NO

Does the child require administration of medication via the gastrostomy tube at the community program? ☐ YES ☐ NO

❑ **Ostomy Care**

Does the child require the ostomy pouch to be emptied at the community program? ☐ YES ☐ NO

Does the child require the established appliance to be changed at the community program? ☐ YES ☐ NO

Does the child require assistance with ostomy care at the community program? ☐ YES ☐ NO

❑ **Clean Intermittent Catheterization (IMC)**

Does the child require assistance with IMC at the community program? ☐ YES ☐ NO

❑ **Pre-set Oxygen**

Does the child require pre-set oxygen at the community program? ☐ YES ☐ NO

Does the child bring oxygen equipment to the community program? ☐ YES ☐ NO

❑ **Suctioning (oral and/or nasal)**

Does the child require oral and/or nasal suctioning at the community program? ☐ YES ☐ NO

Does the child bring suctioning equipment to the community program? ☐ YES ☐ NO

Section III - Authorization for the Release of Medical Information

I authorize the Community Program, the Unified Referral and Intake System Provincial Office, and the nursing provider serving the community program, all of whom may be providing services and/or supports to my child, to exchange and release medical information specific to the health care interventions identified above and consult with my child's physician(s), if necessary, for the purpose of developing and implementing an Individual Health Care Plan/Emergency Response Plan and training community program staff for _____.
(child's name)

I also authorize the Unified Referral and Intake System Provincial Office to include my child's information in a provincial database which will only be used for the purposes of program planning, service coordination and service delivery. This database may be updated to reflect changing needs and services. I understand that my child's personal and personal health information will be kept confidential and protected in accordance with *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA).

I understand that any other collection, use or disclosure of personal information or personal health information about my child will not be permitted without my consent, unless authorized under FIPPA or PHIA.

Consent will be reviewed with me annually. I understand that as the parent/legal guardian I may amend or revoke this consent at any time with a written request to the community program.

If I have any questions about the use of the information provided on this form, I may contact the community program directly.

_____ _____
Parent/Legal guardian signature Date

_____ _____ _____
Mailing Address Postal Code Phone number