Holy Cross School

300 Dubuc Winnipeg, Manitoba R2H 1E4
Phone: (204) 237-4936
www.holycrossschool.mb.ca

NEW STUDENT REGISTRATION

Date: _____ Applying for School Year: _____

Grade: _____

Student Information

Student's LEGAL NAME (as it appears on the student's birth certificate and/or passport):

_____ _____ _____
Legal Last Name | Legal First Name | Legal Middle Name

Gender: ☐ Male ☐ Female Date of Birth: _____
Month / Day / Year

Preferred Name-If Different from Legal Name

_____ _____
Last Name if Different from Legal Name | First Name if Different from Legal Name

Current School Name and Address: _____

Last School Attended: _____ _____ _____ _____
Grade | School Name | School Division | City

Home School Division: _____

Religion: _____ Parish/Place of Worship: _____

Year of: Baptism_____ First Communion_____ Confirmation _____

Manitoba Medical Numbers: _____ _____
Student Personal Health Number (9-digit) | Family Health Number (6-digit)

For Office Use Only

Date received _____

- ☐ Registration fee (non-refundable)
- ☐ Birth Certificate
- ☐ Report Card (if applicable)
- ☐ Confirmation of Permanent Residence

Languages Spoken and Citizenship

Student's First Language: ☐ English ☐ French ☐ Other: (please specify): _____

Country of Birth: ☐ Canada ☐ Other: (please specify): _____

Country of Citizenship: ☐ Canada ☐ Other: (please specify): _____

If another citizen, please indicate status in Canada:

☐ Permanent Resident ☐ Refugee Claimant ☐ Work Permit ☐ Study Permit

☐ Other (please specify): _____

***Copies of Status in Canada documents **MUST BE PROVIDED** at time of registration ***

Aboriginal Identity Declaration

Aboriginal Identity Declaration helps to support the efforts of Manitoba Education and Training and school divisions to plan and improve programs in a way that is responsive to Aboriginal learners. **Providing this personal information is voluntary and optional.** It is being collected in compliance with section 36(1)(b) of the Freedom of Information and Protection of Privacy Act(FIPPA) as it is necessary for and relates directly to the activity of Manitoba and school divisions to plan, deliver and improve programs

I,_____(name of parent/guardian, please print clearly):

- □ Am submitting my child's Aboriginal Identity Declaration for the first time
- □ Am making changes to my child's Aboriginal Identity Declaration
- □ Already submitted my child's Aboriginal Identity Declaration and have no further changes to make at this time

Is your child an Aboriginal person, that is, First Nation (North American Indian), Métis or Inuk (Inuit)?
(Note: First Nations (North American Indian) include Status and Non-Status Indians

If "Yes," check the box(es) that best describe(s) your child now:

- □ Yes, First Nation (North American Indian)
- □ Yes, Métis
- □ Yes, Inuk (Inuit)

Which best describes your child's Aboriginal cultural-linguistic identity? Please select up to two choices.

- □ Anishinaabe (Ojibway/Saulteaux)
- □ Ininiw
- □ Dene (Sayisi)
- □ Dakota
- □ Oji-Cree
- □ Michif
- □ Inuktitut
- □ Other: Please specify _____

Custody Information

Are there any custody orders in place for this child ☐ No ☐ Yes (if yes please provide school with legal documents)

Child lives with: ☐ Both parents ☐ Joint ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster Parents ☐ CFS ☐ Other (please specify): _____

Family Information

Parent/Guardian #1

Last Name: _____ First Name: _____ Relationship to child: _____

Address: _____ Postal Code: _____

Employer: _____ Work Number: _____

Cell Number: _____ Home Number: _____

Email: _____

Parent/Guardian #2

Last Name: _____ First Name: _____ Relationship to child: _____

Address: _____ Postal Code: _____

Employer: _____ Work Number: _____

Cell Number: _____ Home Number: _____

Email: _____

Siblings

Name	Age	School

Emergency Contact Information

If the listed parent(s)/guardian(s) are unavailable, the following are authorized to care for the child in case of an emergency.

Emergency Contact #1

Last Name: _____ First Name: _____ Relationship to child: _____

Cell Number: _____ Work Number: _____ Home Number: _____

Emergency Contact #2

Last Name: _____First Name: _____ Relationship to child: _____

Cell Number: _____Work Number: _____ Home Number: _____

Emergency Contact #3

Last Name: _____First Name: _____ Relationship to child: _____

Cell Number: _____Work Number: _____ Home Number:_____

Medical Information

Family Doctor: _____ Phone number: _____

The school must be aware of any health condition and ongoing prescribed medications

Does your child have a diagnosed medical condition? □ No □ Yes (If, yes please complete attached URIS Form)
If yes, please describe:_____

Is your child on any ongoing prescribed medication? □ No □Yes
If yes, name of medication(s): _____

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

Other relevant healthcare/medical information: _____
_____

Emergency Procedures: If your child should become ill or be injured during the school day, the school will attempt to notify you. In an emergency, your child may be taken to a hospital or clinic for emergency treatment. In the event that an ambulance is deemed necessary the family is responsible for the cost of service.

Signatures

The following signatures verify the above information is true and accurate. I will provide the school with updated information as circumstances change

Date: _____ Parent/Guardian Signature: _____

Parent/Guardian Signature: _____

Note: Registration is not finalized until this application form has been completed and approved. Cheques should be made payable to 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: hcsoffice@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