Christ Church Cathedral School

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V8V 3V7

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Lux Mundi Out-of-School Care - Registration Form

Out-of-School Care is provided from 3:00 - 6:00pm
All Day Care is provided from 7:30am - 6:00pm on School Closure Days

Effective September 1, 2016, the fee for Lux Mundi OSC is $250.00 per month and is payable on the first of each month. The drop-in rate is $18.00 per day and must not be more than 2 days per week in any given month. The fee for All Day Care is $37.00 per day for summer break and all other school holidays and Pro D Days ($20.00 per day for those already paying the monthly rate). Fees are subject to change. All cheques are payable to **Christ Church Cathedral Educational Society.**

Please give the email address that your invoices should be sent to: _____

DATE OF ENROLLMENT YYYY / MM / DD

CHILD

NAME OF CHILD

SURNAME GIVEN MIDDLE NAME

NAME CHILD RESPONDS TO SEX: ☐ M ☐ F

ADDRESS

DATE OF BIRTH YYYY / MM / DD FIRST DAY OF ATTENDANCE YYYY / MM / DD END DATE YYYY / MM / DD

PARENT/GUARDIAN

NAME

ADDRESS PHONE

CITY & POSTAL CODE E-MAIL ADDRESS

PLACE OF WORK PHONE HOURS OF WORK

NAME

ADDRESS PHONE

CITY & POSTAL CODE E-MAIL ADDRESS

PLACE OF WORK PHONE HOURS OF WORK

MEDICAL INFORMATION

FAMILY DOCTOR PHONE

MEDICAL INSURANCE PLAN NUMBER DATE EFFECTIVE YYYY / MM / DD

ALTERNATE PERSON TO CALL/PICK-UP CHILD IN CASE OF EMERGENCY

NAME RELATIONSHIP PHONE

NAME RELATIONSHIP PHONE

PERSONS (OTHER THAN PARENT/GUARDIAN AND EMERGENCY CONTACTS) AUTHORIZED TO PICK UP CHILD FROM FACILITY

NAME PHONE

NAME PHONE

NAME PHONE

PERSONS NOT PERMITTED ACCESS TO CHILD

NAME PHONE

NAME PHONE

ARE THERE CUSTODY ORDERS? ☐ YES ☐ NO IF YES, ATTACH DOCUMENTATION

NAMES OF OTHER CHILDREN LIVING AT HOME

NAME DATE OF BIRTH YYYY / MM / DD

NAME DATE OF BIRTH YYYY / MM / DD

DOES THIS CHILD HAVE ANY KNOWN HEALTH PROBLEMS/MEDICAL DISABILITIES? ☐ YES ☐ NO
IF YES, ATTACH DOCUMENTATION

LIST ANY COMMUNICABLE DISEASES CHILD HAS HAD: _____

HAS HE/SHE HAD ANY RECENT ILLNESS? ☐ YES ☐ NO IF YES, EXPLAIN: _____

ANY ALLERGIES? ☐ YES ☐ NO IF YES, PLEASE LIST: _____

IF YES, ATTACH SPECIAL INSTRUCTIONS TO FOLLOW IN THE EVENT OF AN ALLERGIC REACTION

BASIC SCHEDULE AND RECORD OF IMMUNIZATION AS SUBMITTED BY PARENT/GUARDIAN
(ATTACH IMMUNIZATION RECORD - OR RECORD THE DATES)

First Visit – two months of age: YYYY / MM / DD	Fourth Visit – 12 months of age: YYYY / MM / DD
❑ **Diphtheria**	❑ **Measles**
❑ **Pertussis**	❑ **Mumps**
❑ **Tetanus**	❑ **Rubella**
❑ **Polio**	❑ **Meningococcal C Conjugate**
❑ **Haemophilus Influenza Type b (hib)**	❑ **Varicella (chicken pox)**
❑ **Hepatitis B**	
❑ **Pneumococcal Conjugate**	Fifth Visit – 12 months after third visit: YYYY / MM / DD
❑ **Meningococcal C Conjugate**	❑ **Diphtheria**
	❑ **Pertussis**
Second Visit – two months after first visit: YYYY / MM / DD	❑ **Tetanus**
❑ **Diphtheria**	❑ **Polio**
❑ **Pertussis**	❑ **Haemophilus Influenza Type b (hib)**
❑ **Tetanus**	❑ **Measles, Mumps, Rubella**
❑ **Polio**	❑ **Pneumococcal Conjugate**
❑ **Haemophilus Influenza Type b (hib)**	
❑ **Hepatitis B**	4 to 6 years of age: YYYY / MM / DD
❑ **Pneumococcal Conjugate**	❑ **Diphtheria**
	❑ **Pertussis**
Third Visit – two months after second visit: YYYY / MM / DD	❑ **Tetanus**
❑ **Diphtheria**	❑ **Polio**
❑ **Pertussis**	❑ **Varicella (chicken pox)**
❑ **Tetanus**	
❑ **Polio**	Other Immunizations:
❑ **Haemophilus Influenza Type b (hib)**	YYYY / MM / DD
❑ **Hepatitis B**	YYYY / MM / DD
❑ **Pneumococcal Conjugate**	YYYY / MM / DD

BY MY SIGNATURE BELOW I ACKNOWLEDGE THE FOLLOWING:

I HEREBY GIVE MY CONSENT FOR A STAFF MEMBER TO CALL A MEDICAL PRACTITIONER OR AMBULANCE FOR MY CHILD IN THE CASE OF ACCIDENT OR ILLNESS, IF I CANNOT IMMEDIATELY BE REACHED.

PARENT/GUARDIAN SIGNATURE _____

DATE _____

CAREGIVER SIGNATURE _____

DATE _____