



Christ Church Cathedral School

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Victoria, British Columbia
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, 2018, the fee for Lux Mundi OSC is \$260.00 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 \$38.00 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
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Measles
<input type="checkbox"/> Pertussis	<input type="checkbox"/> Mumps
<input type="checkbox"/> Tetanus	<input type="checkbox"/> Rubella
<input type="checkbox"/> Polio	<input type="checkbox"/> Meningococcal C Conjugate
<input type="checkbox"/> Haemophilus Influenza Type b (hib)	<input type="checkbox"/> Varicella (chicken pox)
<input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> Pneumococcal Conjugate	Fifth Visit – 12 months after third visit: YYYY / MM / DD
<input type="checkbox"/> Meningococcal C Conjugate	<input type="checkbox"/> Diphtheria
	<input type="checkbox"/> Pertussis
Second Visit – two months after first visit: YYYY / MM / DD	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Polio
<input type="checkbox"/> Pertussis	<input type="checkbox"/> Haemophilus Influenza Type b (hib)
<input type="checkbox"/> Tetanus	<input type="checkbox"/> Measles, Mumps, Rubella
<input type="checkbox"/> Polio	<input type="checkbox"/> Pneumococcal Conjugate
<input type="checkbox"/> Haemophilus Influenza Type b (hib)	
<input type="checkbox"/> Hepatitis B	4 to 6 years of age: YYYY / MM / DD
<input type="checkbox"/> Pneumococcal Conjugate	<input type="checkbox"/> Diphtheria
	<input type="checkbox"/> Pertussis
Third Visit – two months after second visit: YYYY / MM / DD	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Polio
<input type="checkbox"/> Pertussis	<input type="checkbox"/> Varicella (chicken pox)
<input type="checkbox"/> Tetanus	
<input type="checkbox"/> Polio	Other Immunizations:
<input type="checkbox"/> Haemophilus Influenza Type b (hib)	YYYY / MM / DD
<input type="checkbox"/> Hepatitis B	YYYY / MM / DD
<input type="checkbox"/> 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 _____