

EARLY MORNING DROP OFF
OPEN 7AM NO DROP OFF AFTER 7:35
EDINBURGH PSA

www.edinburghpsa.com Tel # 514-484-3644

2017/2018 Student Registration Form (please print)

Child's name: Date of birth:
family name first name month day year

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family name first name month day year

Mailing address:

Marital status of parents: (single) (married) (separated) (divorced)
If parents are separated or divorced, full name of who has custody:

Mother's name Home Tel: (....)
Business Tel: (....) Cell Tel: (....) E-mail:

Father's name Home Tel: (....)
Business Tel: (....) Cell Tel: (....) E-mail:

Alternate/emergency contact:
Relation to child:

Alternate/emergency Tel: (....) Cell: (....) E-mail:

MEDICAL HISTORY OF THE CHILD

Medicare No.: Expiry date:

Does your child have a life threatening allergy? Yes No
If yes, please give details concerning the type of problem, severity, and medication required:
.....
.....

Family doctor: Phone No.:

In case of illness/accident, the parent or designated adult will be called to pick up your child.

In the event of an emergency, and where time does not permit phoning the parent or designated adult, or the parent or designated adult is not available for consultation, I agree that care may be provided to my child without my consent, as contemplated in paragraph 1 of article 13 of the *Civil Code of Quebec*. I understand that I will be notified by the quickest means possible if this authority is exercised.
If there are any changes in the medical condition of my child between completing the Medical History of the Child and the end of the school year, the parent or designated adult shall let the Director of the Edinburgh PSA know by telephone and in writing.

Please enroll my child in: 3 days (..) 4 days (..) or 5 days (..)
Monday (..) Tuesday (..) Wednesday (..) Thursday (..) Friday (..)

