

Parkdale-Sherwood Headstart Program
11 Christie Drive
Parkdale, PEI
C1A 5W6
1-902-892-5916

APPLICATION FOR ENROLLMENT

Application reviewed:

Date: _____ Initials _____

Date: _____ Initials _____

Date: _____

CHILD'S NAME: _____ Nickname (if any) _____

HOME PHONE NUMBER: _____

Child's Address _____

_____ Postal Code _____

Sex: Male _____ Female _____ Personal Health Number _____ Exp. Date: _____

Birth Date _____ Age upon application: _____ Years _____ Months

Email address _____

HIGHLIGHTED INFORMATION: (to be filled out by Headstart staff)

Parent/s name/s and other important phone numbers:

Others with permission to pick up the child: _____

Application administration cost \$30.00 enclosed _____ Supply Fee enclosed \$40.00 _____

Deposit Agreement(non refundable) cost \$120.00 enclosed _____

Date paid _____

Parent Information

Mother's Name _____

Address _____

Phone #=s: Work _____ Home _____ Cell# _____

Occupation _____ Hours of Work _____

Place of Occupation _____

Father's Name _____

Address _____

Phone: Work _____ Home _____ Cell# _____

Occupation _____ Hours of Work _____

Place of Occupation _____

Other relevant adults in child's life regarding care:

Siblings: Name and Age

Person(s) designated to deliver or pick up child other than parent:

Name _____ **Address** _____

Phone: Home _____ Cell _____

Relationship to child _____

Name _____ **Address** _____

Phone: Home _____ Cell _____

Relationship to child _____

Who may we contact in an emergency or in the event that your child is sick and parents cannot be reached?

Name _____ **Address** _____

Phone: Home _____ Cell _____

Relationship to child _____

Name _____ **Address** _____

Phone: Home _____ Cell _____

Relationship to child _____

CHILD=S REQUESTED SCHEDULE:

Hours: _____

Full time _____ Part time _____

Starting Date _____

Indicate schedule requested by circling days of the week a.m., p.m. or both:

(A.M.) Monday Tues. Wed. Thurs. Friday

(P.M.) Monday Tues. Wed. Thurs. Friday

How would you like to receive information? _____

Medical History

Child=s Doctor

Name _____ Address _____

Phone: _____

Check off all illnesses child has contacted to date:

Mumps	_____	Measles(Red)	_____
Measles (German)	_____	Diphtheria	_____
Hepatitis	_____	Chicken Pox	_____
Others (Specify)	_____		

Please respond to the following: (dates included if possible)

Last medical checkup _____

Last dental checkup _____

Last vision checkup _____

Last hearing checkup _____

Last stay in hospital _____

Is your child affected by any of the following? If so, please give details.

Allergies _____

Drug Reactions _____

Seizures _____

Speech concerns _____

Is your child presently under doctor's care? _____

If so, explain and list any medication(s) being taken by the child and frequently.

Social Profile

Describe in detail any fears your child has of which you are currently aware.

Describe your child's favorite toy(s) and/or activities.

Describe the method of discipline you use with your child.

Describe any traumatic experiences (accidents, illnesses, etc.) your child has had that may affect his/her adjustment today care.

Is your child affected by nightmares or bad dreams?

Does your child display temper tantrums?

Is your child toilet trained? _____

If not, what specific instructions do you have for the staff regarding this area?

Does your child nap at home? _____

Is there any other information the staff of the centre, who will care for your child, should be aware of that will enable them to provide for his/her needs? Please specify:

Validation of Information

The above information is, to the best of my knowledge, accurate and correct. I am aware that it is my responsibility to notify the staff of Parkdale-Sherwood Headstart Program of any significant changes in this information.

Signature of Parent _____

Multimedia Waiver

I, _____ (parent=s/guardian=s name) give permission to use pictures or videotapes of my child, _____ as a student enrolled at Headstart to use in various publications. This may include promotional material, the Headstart website, various media special reports and in house news bulletins.

In all usage, outside of the Headstart environment, we will endeavor to protect the identity of the child. Additional parental approval will be sought for any other type of usage.

Parent's Signature _____

Date: _____ Headstart Signature: _____

Emergency Medical Form

In the event of a serious injury to my child, _____, if the staff of Parkdale-Sherwood Headstart Program are unable to reach me or my (husband, wife, designate, etc.), I hereby give permission for the supervisor or designated staff person to act on my behalf in obtaining and/or authorizing emergency medical treatment for my child. I understand that any treatment would be on the advice of a qualified medical doctor.

Parent's Signature _____

Date: _____ Headstart Signature: _____

Consent Form For Stewart MacKay Park and Walks

I give my consent for _____ to use the park and to participate in spontaneous walks in the vicinity of Park Royal Church, 13 Christie Drive in Parkdale, with the staff and children of Parkdale-Sherwood Headstart Program. Please note that the park we are referring to is Stewart MacKay Park that is located in our back yard as this is not a completely fenced in play space that we use daily.

Parent's Signature _____

Date: _____ Headstart Signature: _____

Tylenol Permission Form

In the event that your child's temperature reaches a point where we feel Tylenol is required immediately we will call you, but if this form is signed we will administer Tylenol right after speaking with you.

Child's name: _____

Date of Birth: _____

Weight: _____

Amount to be administered: _____

Date: _____

Parent's Signature: _____

Personal Pre-Authorized Debit Plan
Authorization from the Parents to Parkdale Sherwood Headstart to Direct Debit an Account

Instructions:

1. Please complete all sections in order to instruct your financial institution to make payments directly from your account.
2. Please sign the Payment Information on the next page of this document.
3. Return the completed form with a blank cheque marked "VOID" to Headstart.
4. If you have any questions, please write a note or call Carol at Headstart 902-892-5916.

PAYOR/PARENT INFORMATION

Payor Name(s): _____

Address: _____

Telephone: _____

Signature of Payor(s) _____ Date: _____

PAYOR FINANCIAL INSTITUTION/BANKING INFORMATION

Branch Number	Institution#	Account Number

Name of Financial Institution _____

Branch _____

Branch Address _____

City/Province _____ Postal Code _____

PAYEE INFORMATION

Parkdale Sherwood Headstart Inc.
 11 Christie Dr. Ch'town, PE C1B 1L4
 902-892-5916 headstartpei2013@gmail.com

**Personal Pre-Authorized Debit Plan
Authorization from the Parents to Parkdale Sherwood Headstart to Direct
Debit an Account**

PAYMENT INFORMATION

Please confirm/clarify that the payment is a fixed amount of _____

Occurring at bi-weekly intervals yes I agree _____

For those of you not registering for the full summer program I agree to have my fees taken out biweekly for the weeks I am registered.

Yes I agree _____

It is permissible for the Dec. 25, 2017 payment to be decreased due to the days that we are closed that we do not charge you for. Yes I agree _____

DATE: _____

Signature: _____



DEPOSIT AGREEMENT

I confirm my understanding that in placing this deposit of \$150.00 a space for my child _____ will be held until the date agreed upon by both myself and Headstart.

\$30 is an application administration fee.

\$120 will be put towards your child's tuition fees when your child begins at Headstart.

I understand that if I change my mind I am required to give 4 full weeks notice in order to have my \$120.00 portion of my deposit refunded.

Start date agreed upon: _____

Signature: _____

Date: _____