For Office Use Only

☐ First month cash

☐ Signed up for Cash Online

Medicine Hat Catholic Board of Education
St. Louis School
Out of School Care Program Registration Form

STUDENT/FAMILY INFORMATION:

Legal Name: _____
(Last Name) (First Name) (Middle Name)

Street/Mailing Address (Legal land description if a P/O Box): _____

City: _____ Postal Code: _____ Home Phone: _____

Date of Birth: _____ Child's Age as of September 1st: _____ Gender: _____
(Year/Month/Day)

Parent / Guardian	**Parent / Guardian**
Contact 1	**Contact 2**
Does child reside with you? ☐ Yes ☐ No	Does child reside with you? ☐ Yes ☐ No
Relationship to child: _____	Relationship to child: _____
Name: _____	Name: _____
Address (Legal land description if a P/O Box): _____	Address (Legal land description if a P/O Box): _____
City: _____Prov.: _____	City: _____Prov.: _____
Postal Code: _____	Postal Code: _____
Contact Numbers:	Contact Numbers:
Home: _____	Home: _____
Work: _____	Work: _____
Cell: _____	Cell: _____
Email: _____	Email: _____

MEDICAL INFORMATION:

Family Physician: _____Phone Number: _____

Does your child have any allergies? ☐ Yes ☐ No (If you indicated yes, please explain and include severity):

_____

_____

Are your child's immunizations up to date? ☐ Yes ☐ No

Does your child use any medication regularly? ☐ Yes ☐ No (If you indicated yes, please explain in detail):

_____

_____

EMERGENCY CONTACT INFORMATION:
In the event that a Parent/Guardian cannot be contacted, please list two alternate Emergency Contact persons:

Emergency Contact #1	**Emergency Contact #2**
Name: _____	Name: _____
Relationship to child: _____	Relationship to child: _____
Address: (Legal land description if a P/O Box)	Address: (Legal land description if a P/O Box)
_____	_____
City: _____Prov.: _____	City: _____Prov.: _____
Postal Code: _____	Postal Code: _____
Contact Numbers:	Contact Numbers:
Home: _____	Home: _____
Work: _____	Work: _____
Cell: _____	Cell: _____

DESIGNATED PICK-UP PERSON INFORMATION:
Person(s) other than Parent/Guardian or Emergency Contact authorized to PICK-UP child:

Pick-Up Person #1	**Pick-Up Person #2**
Name: _____	Name: _____
Relationship to child: _____	Relationship to child: _____
Contact Phone: _____	Contact Phone: _____

CUSTODY INFORMATION:

Please indicate whether a Parenting Order or Contact Order exists for your child. ☐ Yes ☐ No

***(If you indicated yes, legal documentation is required).**

FIRST-AID CONSENT:

I _____ give my permission to the Out of School Care staff at St. Louis School to
(Print Name)
administer medical attention in the nature of first-aid to my son/daughter _____ in the
(Print Child's Name)
event of an emergency.

Signature: _____ Date: _____

MEDICINE HAT CATHOLIC BOARD OF EDUCATION OUT OF SCHOOL CARE PROGRAM PARENT AGREEMENT:

1. Medicine Hat Catholic Board of Education Out of School Care Programs assume no liability or responsibility for anything that occurs because of false information provided at the time of registration. It is the parents' responsibility to inform the Out of School Care Program Coordinator of any changes that occur after the original registration form was completed. (i.e., phone number, employment, emergency pick up, etc.).
2. Parents or designate must physically accompany their child into the designated program area for all drop-offs and pick-ups, ensuring their child is signed in and out of the program. Children will be released only to authorized persons as stated by the parents or guardians on the registration form. Children WILL NOT be released to anyone not on the registration form.
3. Parents requiring scheduled care agree to provide the hours of care required to the Out of School Care Program Coordinator as soon as possible. Parents are responsible for adhering to this schedule and will advise the Out of School Care Program Coordinator of any changes to arrival and pickup times.
4. In the event of a serious medical emergency, the supervisor will call 911 and then contact the parents or guardians. If a child is ill, the parent(s) or guardian(s) will be contacted and must pick up the child immediately. The Out of School Care Program reserves the right to engage emergency medical assistance for any child left in its care, when such assistance is deemed to be necessary. The expense of the required assistance to be borne solely by the parents or guardians of the child.
5. The parents agree to pay according to the attached fee schedule. Please note fees are subject to change. Service will be cancelled for those who fail to pay.
6. One month's written notice must be submitted to the Out of School Care Program Coordinator to terminate your child's involvement in the program.
7. The program will not operate on school holidays, which include Christmas break, Easter break, and Professional Development days, including teacher's convention.

I have seen, read and agree with the above outlining my responsibilities to the MHCBE Out of School Care Program.

We, the undersigned being the parents and/or legal guardians of _____ (name of child(ren) hereby certify that we have given careful consideration to the participation by our son/daughter in the MHCBE Out of School Care Program and understand fully the nature and character of the risk undertaken by our son/daughter and agree to accept on behalf of the same child, all risks and responsibilities for injury or damage beyond the control of the MHCBE Out of School Care School Program. We further certify, we are hereby releasing the MHCBE Out of School Care School Program, School Administration, and the Medicine Hat Catholic Board of Education and their sub-agents from all claims and demands whatsoever, occurring as a result of damage incurred to the child by reason of activities outside of the authority extended by the MHCBE Out of School Care School Program in the conduct of this project. I consent to the MHCBE Out of School Care School Program sharing information with teachers and staff of the School as needed about my child.

_____ _____

Parent/Guardian #1 Signature Date

_____ _____

Parent/Guardian #2 Signature Date

_____ _____

Out of School Care Representative Signature Date

Start Date: _____

Applying for Provincial Subsidy: ☐ Yes ☐ No

FEE SCHEDULE AND SESSION TIMES:

This schedule is based on a child attending 1, 2, 3, 4 or 5 days each week (pro-rated over an average week, over the duration of entire school year). There are some weeks and months with fewer days than others, however, this schedule takes into account an average week and month over the entire school year. This allows the fee to remain the same price each month.

A reminder that there is NO drop-in price available. Parents MUST commit to between 1 and 5 days per week, on a consistent month-to-month basis. It is the parents' right to not utilize all of the days they have signed up for, but the fee schedule cannot be pro-rated any more than what is listed below. **Fees must be paid upfront each month in order for your child to access the program. Fees can be paid either on-line or by cash to the administrative assistant at the school.**

Hourly Fees

Parents will be charged per time slot at a rate of $5.00/hour.

If parents are accessing all of the OSC blocks daily, a cap of $250.00 /month will be applied. Any family with multiple children (2+) are capped at $200.00 per student/ month.

Child Schedule:
Please place a checkmark (✓) in the slot(s) that you require for the Before & After School Care Program. Licencing regulations require us to have this information on file.

Time Slot:	Monday	Tuesday	Wednesday	Thursday	Friday
Before School					
7:30 a.m. to 8:30 a.m.					
After school					
3:10 p.m. up to **4:30** p.m.					
4:35 p.m. up to **5:30** p.m.					

***** If you require changes to this schedule at any time during the school year, please see the secretary at the front office well in advance of that change.**

A one time fee of $25.00 per family will also be applied at time of registration.