DAKII YADZE CENTRE
WEST MOBERLY FIRST NATIONS

PO Box 90, Moberly Lake, B.C. V0C 1X0
Phone: 788-9447 Fax: 788-9450
Email: kslack@westmo.org

Parent/Guardian Information:

Registration Start Date: ________________
End Date: ________________________

Mother/Guardian First Name: ______________________________ Last Name: ____
Address (*please provide physical and mailing*): ____

____

Home Phone: (   ) ___________________________ Cell Phone: (   ) ___________________________________
Place of Work: __________________________ Work Phone: (   ) ____________________Work Hours: ____________________

Father/Guardian First Name: ______________________________ Last Name: ____
Address (*please provide physical and mailing*): ____

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Home Phone: (   ) ___________________________ Cell Phone: (   ) ___________________________________
Place of Work: __________________________ Work Phone: (   ) ____________________Work Hours: ____________________

Child Information:

1st Child First Name: _______________ Middle Name: _______________ Last Name: ________________
Name child prefers to be called: _______________ __Birth date and year: ___________________________
List any existing medical conditions, medications and/or special attention your child may require.

____

Allergies: ______________________________ Symptoms: _________________________________
Treatment: ______________________________ Medical Number: ____________________________
Physicians Name: ___________________________ Phone: (   ) ____________________________

If your child requires medication to be taken during the program, it MUST be given directly to staff and stored in a locked container to be administered by staff members ONLY.

Parents MUST complete a separate consent form, required by licensing.

2nd Child First Name: ________________ Middle Name: ________________ Last Name: ________________

Name child prefers to be called: ________________ __Birth date and year: ____________________________

List any existing medical conditions, medications and/or special attention your child may require?

____

Allergies: ________________________________ Symptoms: ___________________________________

Treatment: ______________________________ Medical Number: ______________________________

Physicians Name: ______________________________ Phone: (   ) _____________________________

If your child requires medication to be taken during the program, it MUST be given directly to staff and stored in a locked container to be administered by staff members ONLY.

Parents MUST complete a separate consent form, required by licensing.

3rd Child First Name: ________________ Middle Name: ________________ Last Name: ________________

Name child prefers to be called: ________________ __Birth date and year: ____________________________

List any existing medical conditions, medications and/or special attention your child may require?

____

Allergies: ________________________________ Symptoms: ___________________________________

Treatment: ______________________________ Medical Number: ______________________________

Physicians Name: ______________________________ Phone: (   ) _____________________________

If your child requires medication to be taken during the program, it MUST be given directly to staff and stored in a locked container to be administered by staff members ONLY.

Parents MUST complete a separate consent form, required by licensing.

Consents:

Please check each of the following and sign:
I give permission for photographs and videos of my children to be used in any publicity in which the program participates (newspapers, newsletters, funding)   YES (   )   NO (   )

1. I give permission for Dakii Yadze staff to apply sunscreen to my children when outdoors. YES (   )   NO(   )
2. I give permission for Dakii Yadze staff to apply insect repellent to my children when outdoors. YES(   )   No(   )
3. I give permission for my children to participate in occasional excursions with the program that are within 30 minutes walking distance from the facility. YES (   )   NO(   )

Parent Signature: ____ Date: ______________________

Immunization Information:

If you are a client at the West Moberly First Nations Health Centre, your signature on the attached *Consent for Release of Confidential Information* will enable us to obtain a copy of your child's immunization records for our files. If you are a client at another health unit, please provide us with a photocopy of your child's immunization record.

HEAD LICE: Please ensure that your child has been thoroughly checked and treated for head lice before they start the program. Staff will be checking heads throughout the program and will do our best to ensure that those with head lice will be sent home. All eggs, nits, and bugs must be removed before children can return to the program. THERE ARE NO EXCEPTIONS TO THIS POLICY.

Guidance and Discipline Policy:

Our policy on guidance and discipline is as follows:

1. Staff will establish clear, consistent and simple rules for behaviour.
2. Staff will offer straightforward explanations for rules.
3. Staff will guide children towards appropriate behaviour.
4. Staff will approach children on an individual basis.
5. Staff will enforce the rules as needed in order to ensure the safety of all children.

Departing Procedure for ________________________ (child/children's name):

All participants must be picked up by an authorized adult. Parents are responsible for providing alternate adults below who will pick up their child before the program ends.
Pick up time is between 4:30 pm and 4:45 pm. Parents are responsible to alert staff when someone other than those listed below will be picking up their child.

Emergency Contact & Authorized Pickup Persons (at least 2 different home phone numbers):

1st Contact/Pick up Name: ______________________ Phone: ( ) ____________
Relationship to Child: ______________________ Cell: ( ) ____________

2nd Contact/Pick up Name: ______________________ Phone: ( ) ____________
Relationship to Child: ______________________ Cell: ( ) ____________

3rd Contact/Pick up Name: ______________________ Phone: ( ) ____________
Relationship to Child: ______________________ Cell: ( ) ____________

4th Contact/Pick up Name: ______________________ Phone: ( ) ____________
Relationship to Child: ______________________ Cell: ( ) ____________

The following persons are <u>NOT</u> authorized to pick-up my child from the program. (Attach relevant court order.)

Full Name: ______________________
Address: ____
Phone: ( ) ______________________

Full Name: ______________________
Address: ____
Phone: ( ) ______________________

Full Name: ______________________
Address: ____
Phone: ( ) ______________________

Additional Comments & Information:

Do you have any concerns regarding any of the following (*please specify*):

Toileting: ____________________

Diet: ____________________

Fears/Phobia's: ____________________

Other: ____________________

Have there been any significant changes in your child's life in the past year (e.g. a death, separation, etc.)?

____

What kind of activities does your child enjoy at home? ____________________

____

Does your child have any behaviours that concern you? ____________________

Please share any special information regarding sleeping habits, security items, fears, religious or cultural observations etc. ____________________

What languages has your child been exposed to? ____________________

Would you like your child to be exposed to either of the following languages? Beaver ( ) / Cree ( )

Would you be able/willing to volunteer for any of the following (*please check all that apply*)?
( ) Planning ( ) Fundraising ( ) Helping with regular programs
( ) Traditional/Cultural components ( ) Other ____________________

Schedule/Payment Information:

Full day: ( ) $30 Half Day: ( ) $15 Full Day Drop-in: ( ) $30 Half Day Drop-in ( )$15

Please specify who is responsible for the payment of fees.

Name: ____________________ Contact number: (250) ____________________

Address (*both physical and mailing*):____________________

____

Method of payment: Extra-Curricular ( ) Cash/Cheque ( )
Wage Deduction ( ) Other ( ) ____________________

Signature:

Parents Signature: ____________________ Date Signed: ____________________