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*): _____

_____

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 NOT 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: _____