



## SSL PRESCHOOL REGISTRATION o/a Langdon Learning Centre

## Child's Information

Child's Name					GENDER	
Child's Address						
Child's Birth Date	M		D		Y	ADMIN

## Medical Information (Please continue to PAGE 3 for more details, if no medical issues, skip pages 3 &amp; 4)

Allergies?			Immunizations up to date?	
Other?			Y	N
			ADMIN	

## Family Information

Mother's Name		H - PH #	
Address	If different from Childs	C - PH #	
Email Address		Wk - PH #	

Father's Name		H - PH #	
Address	If different from Childs	C - PH #	
Email Address	Provide only if you want 2 emails sent out	Wk - PH #	

## Alternate Contact (for daily Pickups and Emergencies)

**Parents** will always be contacted first in an **emergency**! This alternate person should be available to retrieve your child if you are not available. If you have a day home provider, please put their name in this area. Otherwise, it should be someone you trust and who lives within a 15-min drive to the preschool such as a family member, neighbour or friend. **Should this alternate person change, you must alert us by email.**

Name:		Relation:		Cell Phone:	
911 Address (No PO Box #'s)		City/Province		Postal	

CLASS	Affordability Grant/mo	PARENTS PAY/mo	CLASS TIMES	CHECK BOX	ADMIN
Mon/Wed/Fri AM \$206/mo	<\$75>	\$131	8:15 – 10:45 AM		\$75 REG FEE PD? _____ PAD REC'D? _____ PAD ENTER? _____  NOTES:
Tues/Thurs AM \$144.50/mo	<\$75>	\$69.50	8:15 -10:45 AM		
Tues/Thurs PM \$144.50/mo	<\$75>	\$69.50	11:45 – 2:15 PM		

If you have a child that is kindergarten eligible, please visit our **KINDERCARE** registration form. Our registrations are ongoing but get processed every January. To solidify your spot, please **REGISTER ASAP!** Limited spots available.



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**Authorization to Act in a Medical Emergency**

In the event of a serious illness requiring medical attention, every effort will be made to notify the emergency contact person if the parent or guardian is unavailable. All care and attention will be given to the health and comfort of the student.

I hereby authorize the Director or Head Teacher in charge to obtain or secure such medical advice and treatment as may be deemed necessary for the health and safety of the student.

I agree to accept financial responsibility for and undertake to pay all costs resulting from the medical treatment. I also agree to release the teachers in charge at Stepping Stones Langdon Preschool (Subsidiary of Langdon Learning Centre) from any personal liability that may occur because of giving such medical attention either on or off the preschool property.

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(MM/DD/YYYY)

Parent or Guardian Signature

**FOIP Requirement and Purpose Form**

The information requested on all the forms within this registration package is considered confidential and will be treated accordingly. The information will be used at the discretion of the teacher in charge to assist in caring for the student's health needs, particularly in the event of injury, or illness in the classroom or while attending a school field trip. Only staff & licensing officers will have access to your child's file and can review it at any given time. As a parent you also have the right to review your child's file at any given time.

All matters discussed with parents or guardians either by email correspondence, volunteering in the classroom or on a field trip will be held confidential and are not permitted to be shared with anyone other than the teachers and support staff present. When volunteering in our classroom, you must review our program policies and discipline procedures. You agree to legally abide by these rules and regulations even if your child no longer attends our program.

Pictures will be taken during class activities for sharing with the families enrolled in the Stepping Stones Langdon Preschool program. **If a picture is selected to be used on our website for advertising purposes, the parent or guardian will be contacted prior to and asked for written (email is acceptable) permission to post them.** You must refrain from posting any photos or videos taken at preschool events on any public media (i.e Facebook, Twitter) involving children other than your own, or teachers and support staff without their written consent to do so.

**As the parent or guardian of the above-named child, I certify the information I have provided to Stepping Stones Langdon Preschool is accurate and true. I have read the Parent Welcome Package provided and I acknowledge and understand the requirements for enrollment in this program. Any information provided that is untrue could result in immediate dismissal from the program.**

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(MM/DD/YYYY)

Parent or Guardian Signature



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## Payor's PAD Agreement

## INSTRUCTIONS

1. The Payee must retain this PAD Agreement for at least 12 months after the last Pre-Authorized Debit (PAD) is issued.
2. The Payee can obtain the transaction type code from the Payments Canada website. See Payments Canada Rule 007, Standards for the Exchange of Financial Data on AFT Files.
3. The Payee will insert the number of days required to cancel a payment in the "Cancel Payment" Section (cannot exceed 30 days).

## PAYOR/PAYEE INFORMATION (MANDATORY)

Account Holder(s) Name(s) and Address(es) (the "Payor")

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_

PROVINCE \_\_\_\_\_

POSTAL CODE \_\_\_\_\_

PHONE \_\_\_\_\_

FAX \_\_\_\_\_

EMAIL \_\_\_\_\_

Payee Name and Address (the "Payee") ☐ same as Payor

NAME Langdon Learning Centre

ADDRESS 120, 355 - Centre Street NW

CITY Langdon

PROVINCE AB

POSTAL CODE T0J 1X2

PHONE 403-936-5699

EMAIL langdonlearningcentre@gmail.com

## PAYMENT DETAILS

☐ Specimen cheque marked "VOID" attached.

DESCRIPTION OF PAD (optional)	CPA TRANSACTION TYPE	PAYMENT TYPE (choose one only)	PAYOR ACCOUNT (the Payor's account at the Processing Institution; the "Account")		
		<input checked="" type="checkbox"/> Personal PAD	Institution	Branch I.D.	Account No.
			0		
AMOUNT OF PAYMENT <input checked="" type="checkbox"/> Fixed Amount \$	DATES  Bi-Weekly beginning <input checked="" type="checkbox"/> Monthly beginning		PAYOR FINANCIAL INSTITUTION - NAME AND ADDRESS (the "Processing Institution")		
			PAYEE ACCOUNT (Payee's account for credit - complete if known.)		

## AUTHORIZATION

I/We hereby authorize Payee, in accordance with the terms of my/our account agreement with Processing Institution, to debit or cause to be debited the Account for the purposes indicated in the 'Payment Type' section of this PAD Agreement.

By signing this Authorization, the Payor acknowledges having received and having read a copy of this PAD Agreement, including the terms and

**X**  
Payor Signature

**X**

Payor Signature

Date

Note: If only one signature is required for the Account, then only one Payor need sign. However, if two or more signatures are required, then both or all Payors must sign.

## WAIVER OF PRE-NOTIFICATION (DOES NOT APPLY TO SPORADIC PADS)

I/We waive any and all requirements for pre-notification of debiting, including, without limitation, pre-notification of any changes in the amount of the PAD due to a change in any applicable tax rate, top-up, or adjustment.

**X**

Payor Signature

**X**

Payor Signature

**CANCEL PAYMENT** The Payor may cancel this authorization at any time **15** DAYS NOTICE IS REQUIRED BEFORE THE NEXT PAD WILL BE ISSUED. CANNOT EXCEED 30 DAYS)  
The Payor hereby cancels this Payor's PAD Agreement effective: \_\_\_\_\_




## SSL PRESCHOOL REGISTRATION o/a Langdon Learning Centre

1. This Agreement is subject to any and all applicable laws, including without limitations, any and all applicable laws relating to consumer protection.
  2. Particulars of the Account that Payee is authorized to debit are indicated in the "Payment Details" section on page 1 of this Agreement. A specimen cheque, if available for the Account, has been marked "VOID" and attached to this Authorization.
  3. I/We undertake to inform the Payee, in writing, of any change in the Account information provided in this Authorization prior to the next due date of the PAD.
  4. This Authorization is continuing but may be cancelled at any time upon notice being provided by me/us, either in writing or orally, with proper authorization to verify my/our identity within the specified number of days before the next PAD is to be issued as noted on Page 1, Cancel Payment section. I/we acknowledge that I/we can obtain a sample cancellation form or further information on my/our right to cancel this Acknowledgement from Processing Institution or by visiting [www.payments.ca](http://www.payments.ca).  
  
I/we acknowledge that if I/we wish to cancel this Authorization or if I/we have any questions or need further information with respect to a PAD, I/we can contact the Payee at the telephone number or address set out in this PAD Agreement.
  5. Revocation of this Authorization does not terminate any contract for goods or services that exists between me/us and Payee. This Authorization applies only to the method of payment and does not otherwise have any bearing on the contract for goods or services exchanged.
  6. I/We acknowledge that provision and delivery of this Authorization to Payee constitutes delivery by me/us to Processing Institution. Any delivery of this Authorization to Payee constitutes delivery by the Payor.
  7. If this Authorization is for fixed or variable amount business, personal or funds transfer PADs recurring at set intervals, unless I/we have waived any and all requirements for pre-notification of debiting in the "Waiver of pre-notification" section on page 1 of this Agreement, or unless the change in the amount of any such PAD will occur as a result of my/our direct action (such as, but not limited to, telephone instructions or other remote measures), I/we acknowledge I/we will receive:
    - (a) with respect to fixed amount business or personal PADs, written notice from the Payee of the amount to be debited and the due date(s) of debiting, at least 10 calendar days before the due date of the first PAD, and such notice will be received every time there is a change in the amount or the payment date(s); or
    - (b) with respect to variable amount business or personal PADs, written notice from the Payee of the amount to be debited and the due date(s) of debiting, at least 10 calendar days before the due date of every PAD; or
    - (c) with respect to business, personal or funds transfer PADs, at least 10 calendar days written notice from the Payee of any change in the amount of the PAD which results from a change in any applicable tax rate, a top-up or other adjustment. No pre-notification will be given if the amount of the PAD decreases as a result of a reduction in municipal, provincial, or federal tax. Pre-notification may be given in writing or in any form of representing or reproducing words in visible form, which, if I/we have provided an email address to the Payee, includes an electronic document.
- The amount of pre-notification provided will change when there is a change in the pre-notification requirements contained in the Payments Canada Rules.
8. If this Authorization provides for PADs with sporadic frequency, I/we understand that the Payee is required to obtain an authorization from me/us for each and every PAD prior to the PAD being exchanged and cleared. I/we agree that a password or security code or other signature equivalent will be issued and will constitute valid authorization for the Processing Institution to debit the Account.
  9. I/We acknowledge that Processing Institution is not required to verify that a PAD has been issued in accordance with the particulars of this Authorization, including, but not limited to, the amount.
  10. I/We acknowledge that Processing Institution is not required to verify that any purpose of payment for which the PAD was issued has been fulfilled by Payee as a condition to honouring a PAD issued or caused to be issued by Payee on the Account.
  11. I/We acknowledge that, if this Authorization is for personal or business PADs or for funds transfer PADs that have recourse through the clearing system, a PAD may be disputed but only under the following conditions:
    - (a) the PAD was not drawn in accordance with this Authorization;
    - (b) this Authorization was revoked; or
    - (c) pre-notification was required and was not received.  
I/We further acknowledge that in order to be reimbursed, a declaration to the effect that either (a), (b), or (c) took place must be completed and presented to the branch of Processing Institution holding the Account on or before the 90th calendar day in the case of a personal PAD or funds transfer PAD that has recourse through the clearing system or, in the case of a business PAD, on or before the 10th business day, in each case after the date on which the PAD in dispute was posted to the Account.
  12. I/We acknowledge that any claim made after the periods set out above must be resolved solely between me/us and the Payee and there is no entitlement to reimbursement from the Processing Institution.
  13. I/We acknowledge and agree that if this Authorization is for funds transfer PADs and the Payee does not provide recourse through the clearing system, then no recourse will be provided through the clearing system (that is, I/we will not receive automatic reimbursement in the event of a dispute) and I/we must seek reimbursement or recourse from the Payee in the event a PAD is erroneously charged to the Account.
  14. Unless this Authorization is for a funds transfer PAD that does not have recourse through the clearing system, I/we acknowledge that I/we have certain recourse rights if a debit does not comply with this Authorization. For example, I/we have the right to receive reimbursement for any debit that is not authorized or is not consistent with this Authorization. To obtain more information on my/our recourse rights I/we can contact Processing Institution or visit [www.payments.ca](http://www.payments.ca).
  15. I/We acknowledge that I/we understand that I/we are participating in a PAD plan established by Payee and I/we accept participation in the PAD plan upon the terms and conditions set out herein.

**MEDICATION CONSENT FORM**

Please fill out the following information enabling our trained staff to administer medication to your child. Under government regulations, without proper consent, staff members are not permitted to administer any medication.

**PERSONAL INFORMATION**

Child's Name		<div>Insert Your Child's Photo Here</div>  <div>shutterstock · 118086349 s Photo</div>
Birthdate (M/D/Y)		
Parent Name		
Parent Signature		
Date		

**MEDICAL INFORMATION**

Medical Issue			
Name of Medication			
Prescription #			
Date of Issue		Expiration Date	
Dosage		Time of Day Given	
When to administer?	i.e. Wheezing heavily, coughing heavily, throat is closing, twice a day as prescribed etc..		

**Additional Comments (Instructions, Symptoms etc..) or medical history we should be aware of.**

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Administrative Staff will attach a log form to record when (if) medication is administered. This form will be shared with and initialed by parents, and the staff member who issued the medication.



## Examples of Medicine & Devices



### **All medical devices must be either left on site or transported daily between programs.**

This is a safety rule and is governed by our licensing requirements. Please ensure you have the following packaged in a **clear Ziploc bag** with your **child's first and last name clearly written on the front**.

- The medicine/device must be in its **original container**/packaging with readable instructions.
- The date on the container can **NOT BE EXPIRED**.
- A medical form (provided by the preschool) is filled out **\*\*See Page 3**
- Provide us with a 3" x 5" close-up photo of your child's face.

Ziplock baggies containing medical **devices** will be accessible to all kindergarten aged children and older. All children below kindergarten age will be kept out of reach of children but easily accessible to adults for quick administration. **THE MEDICAL FORM included in the Ziplock baggie is to be used by ALL CAREGIVERS** (guardians, day homes, schoolteachers, etc.). This way we know when the device or medication was last administered.

### **Our part to keep your child safe**

- We are a NUT AWARE preschool.
- We do not allow the sharing of snacks amongst our students/teachers.
- We ask parents of children with severe allergies to supply a special treat for their child during group events.
- Both Primary teachers maintain their First Aid/CPR courses.

Thank you for assisting us to help keep your child safe while in our care.



## ABOUT YOUR CHILD

Thank you for sharing information about your child. For us to maintain a responsive and respectful relationship with you as a family, and for us to care for your child optimally, this information will be very helpful to us. **Please try to give specific answers rather than just yes or no whenever possible.**

**Tell us about your child's personality** (are they shy, outgoing, engaging, reserved? Are they going through a particular rough time in their development (biting, hitting, any fears?) Please feel free to tell us all the wonderful things about your child.

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### Activity Like & Dislikes (games/toys etc.)

Indoor?	
Outdoor?	
Other?	

### Family

Siblings & Ages?	
Pets Names?	

### Cultural Background

Are there holidays you exclude from?	
Are there special events you want us to participate in?	
What is your families first language?	
What discipline strategies do you use, and would you like help with this?	
Tell us more.....	

### Ages & Stages of Development

Is your child speaking at their age level?	
Is your child physically meeting milestones?	
What can they do independently? (eat, toilet, dress themselves etc..)	