



# Registration/Enrollment Package

Thank you for choosing Beyond Our Dreams Preschool and Daycare. We look forward to working with your family as your child grows and develops. Please note that we have requested the information required to follow the guidelines laid out by the Ministry of Education. **Your child's spot is confirmed upon submission of the registration package, the non-refundable first month's fees and last month's fee deposit.**

Fees for the 2022-2023 school year:

Half-day preschool (Mornings 9:00AM to 11:55AM (\$25.00 per day) or afternoons 12:00PM to 2:55PM (\$25.00 per day) or full-day preschool (9:00AM to 2:55PM \$45.00 per day.)

Fees are due on the first day of each month. Please submit by e-transfer at christine@beyondourdreams.ca. Refunds are not given for illness or absence. Income tax receipts will be issued in January of each year. A \$25.00 fee will be applied for any cheques returned NSF.

Indicate which days you would like to enroll your child:

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning					
Afternoon					

Please include the following in your submitted registration package:

<input type="checkbox"/> Completed Registration Forms	<input type="checkbox"/> Immunization Record
<input type="checkbox"/> First Month's Fee	<input type="checkbox"/> Admission Date: _____
<input type="checkbox"/> Last Month's Deposit	<input type="checkbox"/> Discharge Date: _____

## REGISTRATION AND EMERGENCY INFORMATION FORM

Student:

Name: _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
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Date of Birth (DD/MM/YY): \_\_\_\_\_ Home Phone: \_\_\_\_\_

Health Card Number: \_\_\_\_\_ Country of Birth: \_\_\_\_\_

Main Language Spoken at Home: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Postal Code: \_\_\_\_\_

**Parent/Guardian Information:**

**Name:** \_\_\_\_\_ **Relationship to student:** \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_

\_\_\_\_\_ Postal Code: \_\_\_\_\_

Place of Employment:

\_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ ext. \_\_\_\_\_

E-mail: \_\_\_\_\_

Has authorization to pick up student:  Yes  No

**Name:** \_\_\_\_\_ **Relationship to student:** \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_

\_\_\_\_\_ Postal Code: \_\_\_\_\_

Place of Employment:

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ ext. \_\_\_\_\_

E-mail: \_\_\_\_\_

Has authorization to pick up student:  Yes  No

Custody Arrangements:

\_\_\_\_\_

\_\_\_\_\_

Emergency Contacts:

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_

\_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ ext. \_\_\_\_\_

E-mail: \_\_\_\_\_

Has authorization to pick up student:  Yes  No

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_

\_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ ext. \_\_\_\_\_

E-mail: \_\_\_\_\_

Has authorization to pick up student:  Yes  No

Potassium Iodide Pill:

In the event of an accident at the Darlington Nuclear Station, radioactive emissions may occur. One type of radioactive material which may be released are radioiodines. If radioiodines are inhaled, they are absorbed by the thyroid gland. The ingestion of potassium iodide (KI) pills will minimize the amount of radioiodine absorbed by the thyroid. KI pills have been provided to all school and businesses within 10 km.

I give permission for my son/daughter to be administered a potassium iodide (KI) pill:  Yes  No

My child is allergic to iodine:  Yes  No

Additional Information:

Family doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Postal Code: \_\_\_\_\_

Allergies:

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Does your child have anaphylaxis:  Yes  No

Does your child carry an EpiPen?  Yes  No

Medications:

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Medical Conditions (please include any special requirements in respect of diet, rest or physical activity):

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Additional Information (please attach individualized plan, and/or authorization for drug/medication administration form if applicable):

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Finally, how do you see yourself being an extension of what your child learns each day at preschool?

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I certify that the information provided on this form is accurate. Please sign below once you have read through and completed the registration package.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_