P500: Appendix III - Student Registration Form

School District 70 Pacific Rim

School:	Grade:

Program:

☐ **StrongStart** ☐ **Kindergarten** ☐ **Grade 1 to 12** ☐ **Early French Immersion** ☐ **Late French Immersion**

Student Information

Legal Last Name:				Home phone:	
Legal First Name:				Student email:	
Legal Middle Name:				Street Address:	
Usual Last Name:				City, Prov:	
Usual Fist Name:				Postal Code:	
Gender at birth:	☐ Male ☐ Female ☐ X	DOB:		Mailing Address	
Gender Identity				City, Prov.	
Personal Health #:				Postal Code	

Citizenship:	Visa Status:	Expiry Date:
Previous School:	District:	City:

PARENT/GUARDIAN INFORMATION

Last, First name:				Street Address:	
Relationship:				City:	
Can pick up:	**Y/N**	Lives with student:	**Y/N**	Prov, PC:	
Receive mailings:	**Y/N**	Receive email:	**Y/N**	Mailing address:	
Receive autodialer calls:	**Y/N**	Has portal access:	**Y/N**	City	
Home phone:				Prov.	
Work phone:				PC	
Cell phone:				Email address:	

PARENT/GUARDIAN INFORMATION

Last, First name:				Street Address:	
Relationship:				City:	
Can pick up:	**Y/N**	Lives with student:	**Y/N**	Prov, PC:	
Receive mailings:	**Y/N**	Receive email:	**Y/N**	Mailing address:	
Receive autodialer calls:	**Y/N**	Has portal access:	**Y/N**	City	
Home phone:				Prov.	
Work phone:				PC	
Cell phone:				Email address:	

EMERGENCY CONTACTS	Relationship	Home Phone	Work Phone	Cell Phone
Daycare Contact Info:		Can pick up student: ☐ Yes ☐ No		

SCHOOL-AGED SIBLINGS (Legal Names)	Grade	School

CUSTODY/GUARDIANSHIP - PROOF REQUIRED IF APPLICABLE

Student Lives With: ☐ _____ ☐ Other: _____
(Please specify relationship to student) *(Please specify relationship to student)*

Custody: ☐ _____ ☐ Other: _____
(Please specify relationship to student) *(Please specify relationship to student)*

Medical Information: Please mark the box that applies if your child has one of the following serious medical conditions that may require emergency care during school hours – 911 will be called.

☐	Diabetes	☐	Epilepsy with a history of seizures in the past two (2) years
☐	Allergy producing **anaphylactic type response** needing hospitalization. Allergic to:	☐	Blood clotting disorders (e.g. Haemophilia that requires immediate medical care in the event of an injury)
☐	Adrenalin	☐	Other:
☐	Severe asthma requiring emergency treatment		

Doctor: _____ **Phone:** _____

Does your child routinely require medication during school hours? ☐ Yes ☐ No (if yes, please fill out Medication Administration Form)

INDIGENOUS ANCESTRY (If yes, please complete this section)

☐ Status on Reserve ☐ Status off Reserve ☐ Non-status ☐ Metis ☐ Inuit Status Card # _____

Community of Origin: _____ Community of Residence: _____

Education Program Information: Please mark the appropriate box should your child be receiving additional educational supports and services

☐ Student has a Ministry of Education Special Education designation and has been on an Individualized Educational Plan (IEP)

☐ Student has been receiving regular Learning Assistance and/or ELL support

☐ Other

The information on this form is collected under the authority of the *School Act,* Sections 13 and 97. Information provided will be used for educational program purposes and, when required, may be provided to health services, social services, or other support services as outlined in Section 79(2) of the *School Act*. Information on this form will be protected under the *Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection and use of this information, please contact the principal of your school.

Parent / Legal Guardian Signature: **Date:**

Office Use Only

Date Received: _____ Time: _____

Copies obtained: ☐ Birth Cert. ☐ Citizenship ☐ Passport ☐ Driver's Licence ☐ Status Card ☐ BC Care Card

☐ Other: _____

☐ Internet Use Agreement ☐ Photo Release ☐ Medication Form ☐ Speech-Language Screening (Elem only)

MyEdBC Number: _____ Ministry PEN Number: _____

Ministry Special Ed Designation if applicable _____ Current IEP provided ☐ Yes ☐ No