Kapawe'no First Nation
Aboriginal Headstart 2019-2020
REGISTRATION FORM

PERSONAL INFORMATION

Name of Child: _____ **Date of Birth:** ____/____/____
First Middle Last D/M/Y

Address: _____
Street / P.O Box Town Province Postal Code

Phone Number: _____ **Date of Registration:** _____

1. NAME OF PARENT(S) / GUARDIAN(S)

Name: _____
First Middle Last

Relationship to Child: _____

Address: _____
Street / P.O Box Town Province Postal Code

Home Phone Number: _____ **Cell Phone Number:** _____

Work Phone Number: _____

2. NAME OF PARENT(S) / GUARDIAN(S)

Name: _____
First Middle Last

Relationship to Child: _____

Address: _____
Street / P.O Box Town Province Postal Code

Home Phone Number: _____ **Cell Phone Number:** _____

Work Phone Number: _____

EMERGENCY CONTACT

Name: _____
First Middle Last

Home Phone Number: _____ **Cell Phone Number:** _____

Work Phone Number: _____

Relationship to Child: _____

NAME OF PERSON(S) AUTHORIZED TO PICK UP CHILD

1. Name: _____
First Middle Last

Relationship to Child: _____

2. Name: _____
First Middle Last

Relationship to Child: _____

3. Name: _____
First Middle Last

Relationship to Child: _____

Kapawe'no First Nation
Aboriginal Headstart
MEDICAL INFORMATION

Child's Name: _____
First Middle Last

First Nation: _____ **Treaty Number:** _____

Alberta Health Care #: _____

Family Doctor: _____ **Phone Number:** _____

Address: _____
Street / P.O Box Town Province Postal Code

Is the Child on Medication: _____ **YES** _____ **NO**

Medication(s): _____

Dosage & Frequency: _____

Allergies: _____

_____

Special Medical Conditions: _____

_____

Special Diet: _____

_____

History of Previous Serious Illness: _____

_____

Immunization – Has Child been Immunized For The Following: (Parent confirmation required)

- ☐ Birth to 12 Weeks BCG
- ☐ 2 Months DAPTP + HIB (PENTACEL), DDST
- ☐ 4 Months DAPTP + HIB (PENTACEL), DDST
- ☐ 6 Months DAPTP + HIB (PENTACEL), DDST
- ☐ 12 Months MMR / VARICELLA
- ☐ 18 Months DAPTP + HIB (PENTACEL), DDST
- ☐ MENINGITIS

_____ _____

Parent/ Guardian Signature **Date**

Kapawe'no First Nation
Aboriginal Headstart
PARENTAL PARTICIPATION AGREEMENT

I understand that my participation in the Aboriginal Headstart Program will benefit my child and myself as a parent.

I _____ do agree to fulfill my parental obligation to the
Parent / Guardian Name

Aborginal Headstart Program by:

1. Attending workshops or other parent / child activities
2. Ensuring my child attends the program on a regular basis, and contact staff if my child is unable to attend
3. Permitting home visits by staff
4. Attending Monthly Parent Advisory Meetings
5. Volunteering in the classroom and / or chaperoning on field trips etc...
6. Act as a resource person (i.e. sharing talents, interests with children, staff and parents)
7. Participating in fundraising activities when necessary

APPROXIMATE TOTAL PARENTAL INVOLVEMENT OF ONE DAY PER MONTH IS EXPECTED

This can be fulfilled by participating in any of the above mentioned activities or by having others participate in your place i.e. family members, grandparents, extended family. This will be scheduled on a monthly basis by signing up on the "Parent Volunteer Schedule" unless otherwise arranged.

_____ _____
Parent / Guardian Signature Date

_____ _____
Parent / Guardian Signature Date

_____ _____
Witness Signature Date

Kapawe'no First Nation
Aboriginal Headstart
CHILD INFORMATION

Please Describe Child's General Behavior (i.e. Shy, Active):

_____

_____

_____

_____

What are Child's Regular Activities?

_____

_____

_____

_____

Child's First Language: ☐ ENGLISH ☐ CREE

Can Child Speak Clearly: ☐ YES ☐ NO

Does Child Have Siblings: ☐ YES ☐ NO

1. _____ _____
   Siblings Name Age

2. _____ _____
   Siblings Name Age

3. _____ _____
   Siblings Name Age

4. _____ _____
   Siblings Name Age

Please add any additional information pertaining to your child (i.e. fears, habits etc...)

_____

_____

_____

Parent / Guardian Name: _____ Parent / Guardian Signature: _____

Date: _____
mm / dd / yy

Kapawe'no First Nation
Aboriginal Headstart
ACCESS TO INFORMATION AND PRIVACY PROVISIONS

PARENTS / GUARDIANS: (Please Read Carefully)

The information collected on this form as part of the school registration process is personal information as referred to in the Freedom of Information and Protection of Privacy (FOIPP) Act. The FOIPP Act requires that parents / guardians be advised of the collections and use of personal information that are a part of normal school community interaction, such as:

1. *Individual photos that are taken;*
2. *Photos and / or videos of classroom and school activities that are taken and used in the school newsletter, school graduation, or for other purposes within the school;*
3. *Class photos that are taken and used within the school*
4. *Student name and description of activities that are used in the school newsletter and other school communications;*
5. *Student name, photograph and write that are used in the school year end memory book, CD or DVD(if one is produced)*
6. *Student names that are included in an birthday recognition listing, student awards and graduation within the school;*
7. *Students names that are on art work, written material, or other items to be displayed in the school;*
8. *The use of student names and relative contact information for Regional Health Authorities;*

Please note that photos and or videos of school activities that are open to the general public may not restrict such activity at public events.

I hereby grant permission to Aboriginal Headstart Program on behalf of _____, to be recorded and taped; have their work displayed;
Child's Name
have their work reproduced for educational purposes. I understand the production(s); work(s) may be shown as educational displays during open house, parent orientation sessions and other school related activities. Or at school sponsored displays in the community, or used in school publication during the current school year.

☐ YES ☐ NO

_____ _____
Parent / Guardian Signature Date

If you object to any of these uses of information, please notify the Aboriginal Headstart Child Care Worker or Education Director in writing.

Kapawe'no First Nation
Aboriginal Headstart

PARENT'S GOAL SETTING WORKSHEET

PARENT / GUARDIAN NAME: _____

CHILD'S NAME: _____

DATE: _____

PROGRAM REGISTERED IN: _____

1. What are some strengths that you witness in your child?

   _____

   _____

   _____

2. List any areas of concern that you would like addressed during this year's program

   _____

   _____

   _____

3. Are there any medical concerns or diagnosis that the staff should be aware of? (i.e. FAS, ADHD, special medications, vision, hearing, allergies, ect…)

   _____

   _____

   _____

4. What goals and objectives do you see as important or necessary for the staff to focus upon to make this a successful and worthwhile year for your child?

   _____

   _____

   _____

5. Are there approaches to learning or behavior management that you have found effective in working with your child?

   _____

   _____

   _____

6. Note any questions that you might have related to the services that this year's program will be providing your child

   _____

   _____

   _____

Kapawe'no First Nation
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CONSENT FORM

I _____ hereby authorize the Aboriginal Headstart Program
Parent / Guardian Name

to obtain information regarding my child's _____
Child's Full Name

Health, Immunization record and other relevant information required for the program.

I further understand that any information acquired is kept secure and is held in strict confidence by Aboriginal Headstart Personnel.

I also approve the release of records from the Aboriginal Headstart to appropriate health and educational personnel for the benefit of my child.

_____ _____

Parent / Guardian Signature Date

Kapawe'no First Nation
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HEALTH PROMOTION PERMISSION FORM

I give permission for my child _____ to participate in the following
Child's Name
Health promotion activities in cooperation with the Community Health Nurse and Health Department while attending the Aboriginal Headstart Program:

1. Measurement of Height and Weight
2. Vision and Hearing Screening
3. Dental Hygiene Screening
4. Dental Care – brushing teeth and flossing
5. Periodic Head Checks

I also understand that I will be informed of results that I am welcome to contact the Community Health Nurse with any concerns regarding the health and well-being of my child.

_____ _____
Parent / Guardian Signature Date

_____ _____
Parent / Guardian Signature Date

Kapawe'no First Nation
Aboriginal Headstart
FLUORIDE PROGRAM

Child's Name: _____ Date of Birth: _____

Male: _____ Female: _____

Address: _____ Postal Code: _____

Phone Number: _____ Work Number: _____

Full Treaty Number: _____

Health History

	YES	NO	NOT SURE
1. Does your child have any heart problems?	☐	☐	☐
2. Does your child have any bleeding problems?	☐	☐	☐
3. Has your child ever had serious health problems?	☐	☐	☐

Comments: _____

_____

_____

I consent to have my child receiving fluoride varnish, dental sealants (plastic coating), and temporary fillings for cavities (as required).

_____ _____

Parent / Guardian Signature Date

** Complications or reactions to these procedures are unusual. However, if your child has any complications or reactions to these services, please contact the nurse or dental therapist.*

Parent / Guardian Name

Date

Parent / Guardian Signature