



AFTER-SCHOOL ENROLLMENT FORM

| | | | |
|-------------------|------------|--------------------|------------|
| Child's Name | _____ | Date of Enrollment | DD/MM/YYYY |
| Date of Birth | DD/MM/YYYY | Date of Discharge | DD/MM/YYYY |
| Mother's Name | _____ | Phone (home) | _____ |
| Address | _____ | Phone (mobile) | _____ |
| Work Place | _____ | Phone (work) | _____ |
| E-Mail | _____ | | _____ |
| Father's Name | _____ | Phone (home) | _____ |
| Address | _____ | Phone (mobile) | _____ |
| Work Place | _____ | Phone (work) | _____ |
| E-Mail | _____ | | _____ |
| Child lives with: | _____ | | |

| | | | |
|------------|-------|--------------|-------|
| 1 Name | _____ | Relationship | _____ |
| Address | _____ | Phone (home) | _____ |
| Work Place | _____ | Phone (work) | _____ |
| 2 Name | _____ | Relationship | _____ |
| Address | _____ | Phone (home) | _____ |
| Work Place | _____ | Phone (work) | _____ |

| | | | |
|---|-------|--------------|-------|
| 1 Name | _____ | Phone Number | _____ |
| 2 Name | _____ | Phone Number | _____ |
| 3 Name | _____ | Phone Number | _____ |
| Is there anyone who is specifically not permitted to have contact with the child? | | | |
| Name | _____ | Relationship | _____ |

Medical Information

Doctor's Name _____ Phone Number _____
Address _____
Health Card No. _____ - _____ - _____ Initials _____
Previous Communicable Diseases: _____ Date _____
_____ Date _____
Previous Illnesses or Injuries: _____ Date _____
_____ Date _____
Known Allergies & Treatments: _____ Date _____
_____ Date _____

If requiring an epi-pen/inhaler, please enclose a photo of your child and specify details (see Consent Form) .

Please attach a copy of child's "yellow card" as proof of immunization

Immunization exemption? Please explain: _____

Special diet requirements _____

After-School Care Registration

Choose number of days, preferred day, and preferred time.

- | | | | |
|---|-------------|-------|--|
| <input type="checkbox"/> After-School Care | 2:30 – 5:45 | \$250 | Jean-Robert Gauthier |
| <input type="checkbox"/> Before-School Care | 7:30 – 9:00 | \$125 | Barrhaven Public, Michaele Jean and Elizabeth Ann Seton |
| <input type="checkbox"/> After-School Care | 4:00 – 5:45 | \$125 | |

Please attach your post-dated cheques for the first day of each month. Please note that your deposit cheque is held, interest free, in lieu of your last month's payment. If the child is withdrawn from the program without due notice (one month), the advance fee will not be refunded, whether or not the child attends during the notice period. Any advance payments in excess of one month will be refunded if the child is withdrawn.

I/We have been provided with a copy of the **Policies and Procedures Handbook** set forth by A Gym Tale Inc. for its School-Age Care program. I/We have read these policies and procedures completely and carefully. I have attached to this form all of the necessary medical information.

Name of Parent/Guardian

Name of Director

Signature of Parent/Guardian

Date

Signature of Director

Date

THANK YOU!