CHILD'S INFORMATION

Name:		**D.O.B: (dd/mm/yy)**
Street Address:	**City:**	**Postal Code:**

PARENT / GUARDIAN INFORMATION

☐ MOTHER ☐ STEPMOTHER ☐ FATHER ☐ STEPFATHER ☐ PARTNER ☐ LEGAL GUARDIAN

Name:		**Email:**	
Home Address: ☐ Same as child		**City:**	**Postal Code:**
Home Phone:	**Cell Phone:**		**Work Phone:**
Employer: ☐ Self Employed			
Employer Address: ☐ Same as home		**City:**	**Postal Code:**

☐ MOTHER ☐ STEPMOTHER ☐ FATHER ☐ STEPFATHER ☐ PARTNER ☐ LEGAL GUARDIAN

Name:		**Email:**	
Home Address: ☐ Same as child			
Home Phone:	**Cell Phone:**		**Work Phone:**
Employer: ☐ Self Employed			
Employer Address: ☐ Same as home		**City:**	**Postal Code:**

EMERGENCY CONTACTS / ALTERNATE AUTHORIZED INDIVIDUALS FOR PICK-UP (optional)

You must inform the centre if a person from the list below will be picking up your child

Name:	**Name:**	**Name:**	**Name:**
Relationship:	**Relationship:**	**Relationship:**	**Relationship:**
Phone:	**Phone:**	**Phone:**	**Phone:**

INDIVIDUALS NOT AUTHORIZED TO PICK-UP

Are there custody arrangements pertaining to the legal right of access to your child? ☐ YES ☐ NO

If **YES,** please provide a copy of the appropriate legal documentation. List below the name(s) of the individuals prohibited from accessing/picking up you child:

Name:	**Name:**	**Name:**
Relationship:	**Relationship:**	**Relationship:**

ALLERGIES AND SPECIAL DIETARY REQUIREMENTS

If you child is diagnosed with Anaphylaxis an Anaphylaxis Emergency Plan Form must be complete

Food Allergy:	**Reaction:**
Medication Allergy:	**Reaction:**
Insect Allergy:	**Reaction:**
Food Sensitivity:	**Reaction:**

HEALTH ISSUES

Does your child have any special conditions (i.e. Seizures, Diebetes...) that require medical attention? (If yes, please explain below) ☐ Yes ☐ No

Medications Required (be specific):

Previous Communicable Diseases and Conditions:

Chickenpox ☐	Measels ☐	Whooping Cough ☐	Fifth Disease ☐	Hepatitis ☐
Tonsilitis ☐	Mumps ☐	Menginigitis ☐	Hand, Foot, and Mouth ☐	Asthma ☐
Strep Throat ☐	Rubella ☐	Mononucleosis ☐	Frequent Colds ☐	Impetigo ☐
Diabetes ☐	Seizures ☐	Ear Infections ☐	Tubes In Ears ☐	

Do you have any physical or developmental concerns for your child? If yes, please explain below: ☐ Yes ☐ No

REQUEST FOR PICTURE CONSENT

There are various times when pictures of the children will be taken, either by teachers, other parents, or members of the media. We would like your permission to use these pictures of your child(ren) for fundraising, program promotion, social media, and various artistic displays around the school.

☐ I consent
☐ I **DO NOT** consent

For KAFRC to take pictures of my child and use them for fundraising, promotional activities, and social media.

PARENT ACKNOWLEDGEMENT

- I have read the KAFRC Parent Handbook and agree to comply with the rules and regulations specified
- My child is able to participate in the full range of activities that Kafrc offers
- I give consent to allow KAFRC staff to communicate with my child's school about items that concern my child.
- I permit my child to go on supervised excursions outside KAFRC
- I will not hold KAFRC responsible for lost or stolen items
- I will not hold KAFRC, its staff or volunteers responsible for accidents which may occur
- I understand the legal obligation of the staff to report any suspected abuse
- I understand that KAFRC may decline a child due to physical and/or verbal aggression towards staff or other children or if the safety of the child/others is at risk
- I understand that emergency medical transporation will be arranged for my child in the event of an emergency
- I understand that a late fee of $1 per minute will apply when children are picked up after the centre's closing time.

Photo Consent & Parent Acknowledgment Sign Off: *by typing your name in this box you agree to all statements above* **Date:** d d /m m m / y y y y

OFFICE USE ONLY

ADMISSION DATE:	**DISCHARGE DATE:**	
RE-ENTRANCE DATE:	**DISCHARGE DATE:**	

Original - File Copy - Program Binder