



# Oakville Parent-Child Centre

## ADVENTURE EXPRESS -SUMMER 2010

Please refer to the Fee Schedule for more information.



Please indicate your 1<sup>st</sup> and 2<sup>nd</sup> choice of program and location for the month of **JULY**:

Program Days	Age Group (Tod or Pres)	Time	Location	Program Code	WL
1.					
2.					

Please indicate your 1<sup>st</sup> and 2<sup>nd</sup> choice of program and location for the month of **AUGUST**:

Program Days	Age Group (Tod or Pres)	Time	Location	Program Code	WL
1.					
2.					

<b>Child's Name:</b>					
First		Last		Commonly Used Name	
<b>Date of Birth:</b>	Month	Day	Year		
<b>Address:</b>			<b>Sex:</b>	M	F
<b>Town:</b>	<b>Postal Code:</b>	<b>Home Phone#:</b>			

Name of Mother: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
First Last

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

Cellular Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Place of Business: \_\_\_\_\_ Bus. Phone #: \_\_\_\_\_

Business Address: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Name of Father: \_\_\_\_\_ Home Phone #: \_\_\_\_\_  
First Last

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

Cellular Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Place of Business: \_\_\_\_\_ Bus. Phone #: \_\_\_\_\_

Business Address: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

<b>Are both parents authorized to pick the child up? Yes ( ) No ( ). If no, please explain: _____</b>
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**In the case of emergency, I give permission to the staff of Oakville Parent-Child Centre to authorize necessary medical treatment for my child.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Please complete the reverse side of this form...*



Please give the names, addresses and telephone numbers of **three (3)** local friends or relatives that would assume responsibility for your child in the event of emergency, or who are authorized to pick your child up.

1.	Name:	Daytime Phone #:	Cell Phone #:
	Address:		Relationship to child:
2.	Name:	Daytime Phone #:	Cell Phone #:
	Address:		Relationship to child:
3.	Name:	Daytime Phone #:	Cell Phone #:
	Address:		Relationship to child:

Family Doctor: \_\_\_\_\_ Telephone #: \_\_\_\_\_

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

Previous Communicable Diseases: \_\_\_\_\_

Special medical condition or known allergies: \_\_\_\_\_

Does your child have an epipen? \_\_\_\_\_ Does your child have a puffer? \_\_\_\_\_ Home use only? \_\_\_\_\_

Are you involved or on the waiting list for: \_\_\_speech services \_\_\_integration services \_\_\_other: \_\_\_\_\_

**RECORD OF IMMUNIZATION: If chart below has been completed for Discovery Station program, please disregard. If your child is not being immunized, please contact the office and request a "Statement of Conscience".**

Date			Pertussis	Diphtheria	Tetanus	Polio	Measles	Mumps	Rubella	Haemophilus B
Year	Month	Day								

**General Information Booklet**

I have read and understand the policies as outlined in the Oakville Parent-Child Centre's *Discovery Station General Information Booklet*.

**Signature of Parent:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**VOLUNTEER PROGRAM** – Please share your hidden talents! Assistance is needed in the following areas:

- Office Volunteer – Assist with library, Daisy's Duds and mail-outs.

**How did you hear about the Centre?**

Friend ( ) Advertisement ( ) Other: ( ) please specify: \_\_\_\_\_

**OFFICE USE ONLY**

Location:	Payment Required:	Date Paid:	Amount:
	Registration fee		
July:	July's Payment		
August:	August's Payment		

Date/Time of Data Entry: \_\_\_\_\_ Withdrawal Date: \_\_\_\_\_