



SURREY ASSOCIATION FOR EARLY CHILDHOOD EDUCATION

SERVING THE CHILDREN OF SURREY SINCE 1973

SAECE PROGRAM MAILING ADDRESS: BOX 34161, 17790 #10 HWY, SURREY BC V3S 8C4

MARY JANE SHANNON	OLD YALE ROAD	HENRY BOSE	LATIMER ROAD	PROGRAM OFFICE
10682 144 Street Surrey BC V3T 4W1 Ph: 604-588-6818	10135 132 Street Surrey BC V3T 3T6 Ph: 604-588-4233	6550 134 Street Surrey BC V3W 4S3 Ph: 604-599-9900	19233 60 AVENUE Surrey BC V3S 2T5 Ph: 604-576-0221	Ph# 604-576-4434 Fax# 604-576-0221 saecemail@yahoo.ca

SAECE PRESCHOOL REGISTRATION FORM: (Please check the classroom and session your child will attend)

School Preferred	Morning session	Afternoon session *Where offered
<input type="checkbox"/> Mary Jane Shannon Elementary	<input type="checkbox"/> 2 Days per week - Tu/Th	<input type="checkbox"/> 2 Days per week - Tu/Th
<input type="checkbox"/> Old Yale Road	<input type="checkbox"/> 3 Days per week - M/W/F	<input type="checkbox"/> 3 Days per week - M/W/F
<input type="checkbox"/> Henry Bose Elementary	<input type="checkbox"/> 5 Days per week - M/T/W/T/F	<input type="checkbox"/> 5 Days per week - M/T/W/T/F
<input type="checkbox"/> Latimer Road Elementary		

* Sessions may be cancelled due to lack of enrollment

Child's Name: _____ Male ___ Female ___
Last First

Address: _____ Home Phone: _____
 _____ Postal Code: _____

Date of Birth: ____/____/____ (yr/mo/day) **Start Date:** ____/____/____

Place of Birth: _____ **Last Day:** ____/____/____

Name ** (Please indicate whom to contact first)	Home Ph #	Work Phone/Cell Phone #
Mother/Guardian: _____		
Father/Guardian: _____		

PERSON(S) TO CONTACT IN CASE OF EMERGENCY (* after parent/guardian):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Family Doctor: _____ Dr.'s Hospital: _____

Address: _____ Phone: _____

Child's Care Card # _____ **Copy of Birth Certificate:** yes ___ no ___

Family Dentist: _____ Phone: _____

Address: _____

PERSON(S) OTHER THAN PARENT/GUARDIAN AUTHORIZED TO PICK UP CHILDREN:

** MUST BE 19 YEARS OR OLDER

 _____ Phone: _____
 Phone: _____
 Phone: _____

OTHER CHILDREN LIVING AT HOME:

Name	Relationship	Date of Birth

INSTRUCTIONS FOR CARE:

Comments (please specify)

1. Health Problems, Medications _____
2. Allergies _____
3. Special Diet _____
4. Food Dislikes/Eating Habits _____
5. Religious or Ethnic Observations _____
6. Language Spoken (if other than English) _____
7. Toileting _____

MEDICAL RECORD – Licensing requires that our program be aware if your child has up to date immunizations (shots). If you have chosen not to have your child immunized, please note. This does not affect enrollment of your child.

Immunization Record: Dates

Diphtheria	Tetanus	Pertussis	Polio
Measles	Mumps	Rubella	Other

COMMUNICABLE DISEASES: Please check the diseases your child has had and dates if known:

- ___ Chicken Pox Date: _____ ___ German Measles Date: _____
 ___ Mumps Date: _____ ___ Red Measles Date: _____
 ___ Whooping Cough Date: _____ ___ Rheumatic Fever Date: _____
 ___ Infectious Hepatitis Date: _____ ___ Other _____ Date: _____

IF YOUR CHILD HAS COMPLETE IMMUNIZATIONS: (please check one)

- Written proof of vaccinations attached
- Written proof of vaccinations unavailable

IF YOUR CHILD HAS INCOMPLETE IMMUNIZATIONS:

- My child has had some vaccinations
- My child has no vaccinations

Parent/Guardian Signature

_____ I do not know

DEVELOPMENTAL INFORMATION

Has your child had any serious accidents or illnesses / Operations or hospitalizations?

Does your child have any physical disabilities (hearing aids, splints, etc.) staff should be aware of?

MISCELLANEOUS

Has your child had other group experiences away from home (Preschool or Daycare)?

Yes No Type of Care: _____

Do you have any concerns regarding your child's development (ie. behavior, speech, eating habits, physical coordination/balance, etc...)? _____

Does your child have any special fears (dogs, darkness, etc.)? _____

Does your child have any special interests such as music, art, performing for others, leading other children, engaging in physical activities, etc? _____

Is there any additional information we should have concerning your child that would help us to understand him/her better?

Are there any other services for your child we should be aware of (ie. Speech/language therapy)?

What are you hoping to have your child gain from this preschool experience?

**** PLEASE NOTE: If there is a Custody Order (or Agreement) in effect, or Persons NOT AUTHORIZED to pick-up your child from the SAECE Preschool Program, a written copy must be in your child's file. Thank you.**

Parent(s)/ Guardian(s) Additional Comments: _____

How did you hear of SAECE?

- Someone who is / was involved with SAECE _____
- School _____
- Newspaper / Advertising _____
- Medical Professional (name) _____
- Other _____

Would you be interested in volunteering on the Board of Directors, or helping in some other way (ie. Helping clean toys or equipment, year end clean up) ? YES _____ NO _____

If Yes, Name please _____

I am interested in helping with: _____



PERMISSION FORM

I give permission for my child: _____

To participate in spontaneous outings, i.e. off the school grounds, such as walks, etc., throughout the school year.

_____ YES _____ NO

To take part in Field Trips that are planned by the SAECE Classroom Staff, these may include walking field trips, parent transportation, or the use of a bus or public transit (with supervision)

_____ YES _____ NO

** Adequate notice will be given of each field trip so that Parent/Guardians have the opportunity to decide about their child's participation in a particular Field Trip.*

To be photographed and/or video taped while involved in activities at the SAECE Classrooms, for classroom use. I understand that the name of my child and any pictures **will not** be published without my expressed permission

_____ YES _____ NO

To be seen by Public Health Personnel, if and when needed.

_____ YES _____ NO

To receive emergency medical care as deemed necessary by the class Supervisor or staff.

_____ YES _____ NO

Signature of Parent/Guardian

Please print name

Date

Signature of Social Worker as applicable

Please print name



EMERGENCY PERMISSION FORM (This form will be taken on all outings)

CHILD'S NAME: Surname (Last), First Name(s) _____

BIRTHDATE: _____ Year / Month / Day

ADDRESS: _____

MOTHER'S /GUARDIAN'S NAME: _____

Home Phone _____ Work / Cell Phone _____

FATHER'S/ GUARDIAN'S NAME: _____

Home Phone _____ Work / Cell Phone _____

EMERGENCY CONTACTS: (Other than Parents/Guardians)**

- | | | |
|----|-------|-------|
| 1. | _____ | _____ |
| | Name | Phone |
| 2. | _____ | _____ |
| | Name | Phone |

CHILD'S DOCTOR _____ Phone: _____

Date of most recent Tetanus shot _____ **CareCard #** _____

ALLERGIES OR MEDICATIONS: _____

Child's Dentist _____ Phone _____

1. It is our policy that we notify a parent when a child is ill or needs medical attention. Staff will make every effort to contact parents/guardians or emergency contacts listed in this registration package. **** It is very important we have contact information (home, cell, work numbers).** If we are not able to reach the family or emergency contacts named in your child's file, a staff member, school person, teacher, or responsible adult will either accompany the child in the ambulance or proceed to the emergency center as soon as possible.
2. Please sign the consent below so that we can take appropriate action on behalf of your child. Return the signed consent to the preschool center immediately. This consent form will go with your child to the emergency center if a serious accident or injury occurs.
3. **I hereby give consent for my child _____, when in need of medical attention, to be taken to the nearest emergency center if I cannot be contacted.**

Signature of Parent/Guardian

Date

Signature of Social Worker (as applicable)

* A photo of your child will be added to this form for emergency use only.

PLEASE READ AND UNDERSTAND THIS SECTION BEFORE SIGNING:

***Registration and Fundraising Fees:** A **\$ 30.00 non-refundable**, registration fee is required. The Registration fee is not part of the tuition fee. SAECE does not require families to participate in classroom fundraising activities, but each **family** (not each child) will provide a **\$ 20.00 Fundraising Fee**, once per school year, instead.

Monthly Tuition: **First month in full and half of last month's tuition is required for your child to start (ie: September 2013 fees, plus half fees for June 2014 are due in September, 2013)***unless other arrangements have been made with the Program Office. Tuition Fees are **equal monthly amounts** (Sept. to June) and are due the 1st of each month. Post-dated cheques are preferred. **If you have applied for Childcare Subsidy**, SAECE requires a half month's tuition each month while waiting for authorization from the Childcare Subsidy office. ** Tax receipts for tuition are issued each February (for the previous calendar year).

***NSF Cheques:** **NSF cheques are to be replaced by cash or money order, plus a \$20.00 service charge.** The child/ren may be unable to attend until fees and the service charge are received. SAECE reserves the right to offer the space/s to another family after this time unless alternate arrangements have been made with the Program Office.

***Non-attendance:** **I understand and agree that tuition fees are still due and payable if my child/children do not attend for any reason (i.e. holidays, illness, etc.). SAECE does not operate as a drop-in program and payment for your child's space is required. Without payment, your child's space will not be held. Families will be invoiced for fees owing.**

***Safety:** In order to safeguard all the children and to provide a safe learning environment I understand, and agree, that should my child require additional supervision in the classroom (ie. behavior / safety concerns, developmental delays), and if that support is not available, it may be necessary to withdraw my child from the preschool until such additional support is provided.

***Notice to Withdraw:** **I understand and agree that I will give one month's notice in writing to the Supervisor, or, I will pay one month's fees in place of notice, if it becomes necessary to withdraw my child/ren from SAECE for any reason.**

AS A PARENT /GUARDIAN OF _____ I AGREE TO THE ABOVE.
(Child's name)

(Signature)

(Date)

Please Print Parent / Guardian Name

Please contact the Program Office if you have any questions.