SMLC SPANISH MONTESSORI LEARNING CENTRE teaching • discovering • playing

1215 3rd Avenue South, Lethbridge AB T1J 0J7
Phone: 403-5243436
Fax: 403-524-3437
Web: lethbridgesmlc.com

Out of School Program

OFFICE USE ONLY	Enrolment Date (YYYY-MM-DD):	Start Date (YYYY-MM-DD):
	Days Attending: ☐ M ☐ T ☐ W ☐ TH ☐ F	
	Approved by:	

REGISTRATION FORM

Child's Information

Last Name:	First Name:		Middle Name:
Date of Birth (YYYY-MM-DD):	Age:	Gender: ☐ M ☐ F	Nickname (If Any):
Child's Address:			
Alberta Health Card Number:			
Family Doctor:		Phone Number:	
Clinic Name:		Clinic Address:	
School:		Grade:	

Medical Details
Does your child have any medical problems that we should be made aware of? Please give details below:

Allergies
Does your child have any allergies that we should be aware of? e.g. food, animals, etc. Please give details:

Long Term Medication
Is your child on any long-term medication that we should be made aware of? Please give details below:

Special Dietary Requirements
Does your child have any special dietary requirements? e.g. Vegetarian. Please give details below:

Does your child have any physical difficulties/delays? ☐ Y ☐ N

Does your child has any special or unique forms of communication to express him/herself? ☐ Y ☐ N

Immunization up to date: ☐ Y ☐ N

If applicable, please provide a letter confirming the mild/moderate need of your child. This letter can be obtained from The following sources: your physician, the Health Unit, Children C.A.R.E Center, Social Worker, and Speech Therapist.

Please provide both parent/legal guardian information.

Family Information – Parent/Legal Guardian 1		
Last Name:	First Name:	Date of Birth (YYYY-MM-DD):
Home address (if different from child's):		
Home Phone:	Cell Phone:	Email Address:
Occupation:	Employer:	Work Phone:

Family Information – Parent/Legal Guardian 2		
Last Name:	First Name:	Date of Birth (YYYY-MM-DD):
Home address (if different from child's):		
Home Phone:	Cell Phone:	Email Address:
Occupation:	Employer:	Work Phone:

Child lives with:	☐ Mother & Father	☐ Mother	☐ Father	☐ Guardian

Declaration by Parent/ Legal Guardian

The information provided in this document is true, correct and complete. I have identified all parents and legal guardians for this child. The individuals identified in the "parent/legal guardian" section have the right to view/change the child information, visit/pick-up and make decisions for this child, unless otherwise indicated here and supported with legal documentation.

Further, I understand that it is my responsibility to notify Spanish Montessori Learning Centre should the above information change.

Parent/Legal Guardian 1 Signature	Parent/Legal Guardian 2 Signature	Date (YYYY-MM-DD)

In the event we are not able to contact you the following individuals will be contacted regarding the care of your child. SMLC will release the child into their care in case of an illness or emergency.

***NOTE**: Persons listed below will be required to show identification before we release the child into their care.*

Emergency Contact 1 Information		
Last Name:	First Name:	
Home address (No PO Boxes):		Relationship to child:
Home Phone:	Cell Phone:	Work Phone:

Emergency Contact 2 Information		
Last Name:	First Name:	
Home address (No PO Boxes):		Relationship to child:
Home Phone:	Cell Phone:	Work Phone:

Emergency Contact 3 Information		
Last Name:	First Name:	
Home address (No PO Boxes):		Relationship to child:
Home Phone:	Cell Phone:	Work Phone:

PERMISSION FORMS

Child's Name: ____

Medical Care

In the event of an emergency or necessary hospital care when I cannot be reached, I give permission for medical procedures deemed necessary by my doctor or any other physician chosen by those involved in the care of my child(ren). I hereby indemnify Spanish Montessori Learning Centre for any costs in respect to medical services. I understand and agree with the conditions outlined by Spanish Montessori Learning Centre. I hereby release Spanish Montessori Learning Centre and its employees for reserving the right to discontinue services for non-compliance of program conditions.

______________________________ ______________________________

Parent/Legal Guardian Signature Date (YYYY-MM-DD)

Administration of Medication

In the event that medication needs to be administered during the program hours, I hereby give permission to Spanish Montessori Learning Centre to administer the medication to my child(ren). I understand that the prescribed medication must be in the original container labelled with the pharmacy name, child's name, doctor's name, dosage, name of mediation, and time to be taken.

______________________________ ______________________________

Parent/Legal Guardian Signature Date (YYYY-MM-DD)

Consent for use of Personal Image and Information

This form is designed for you to give authorization to Spanish Montessori Learning Centre to use your child's personal image and personal information in print, audio or video format. A personal image may include photographs and audio or video recordings. Personal information may include information such as your child's name and age.

I understand that my child(ren) may be photographed and/or videotaped during normal business hours at Spanish Montessori Learning Centre, for fieldtrips or activities. I understand that these photographs and videos may be used in promoting childcare services, either in print or on the Internet. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses.

☐ *I authorize Spanish Montessori Learning Centre to use my child's personal image and information in print, audio and video.*

☐ *I do not authorize Spanish Montessori Learning Centre to use my child's personal image and information in print, audio and video.*

______________________________ ______________________________ ______________________________

Parent/Legal Guardian Name (Print) Signature Date (YYYY-MM-DD)

Practicum Students

Spanish Montessori Learning Centre is used as a practicum setting for students enrolled in the Lethbridge College Early Childhood Education (ECE) program.

I understand that my child(ren) may be photographed and/or videotaped during by a practicum student while they are carrying out their studies at Spanish Montessori Learning Centre. I understand that my child's personal information and image is kept confidential, and will only be reviewed by staff members, students and ECE college supervisors only for educational purposes.

______________________________ ______________________________ ______________________________

Parent/Legal Guardian Name (Print) Signature Date (YYYY-MM-DD)

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Out of School Program

PARENT CONTRACT – JUNE 2021 – AUGUST 2022

OUT OF SCHOOL CARE FEE TABLE – SCHOOL YEAR	OUT OF SCHOOL CARE FEE TABLE – SUMMER
Half day **$40** **(e.g., PD days/No class)**	**Summer** **$750/month**
Half days/week **$170/month** **(e.g., Children attending either morning or afternoon class)**	**3 days/Week** **$550/month**
	2days/ Week **$480/month**
Full day **$65** **(e.g., PD days/No class)**	
Full days/week **$300/month** **(e.g., Christmas, Easter, and/or February break)**	*****Fee rates will be reviewed annually in September and are subject to change*****

On admission of my child(ren) to Spanish Montessori Learning Centre Inc. , I agree to comply fully with the requirements and policies of the program and the terms of this agreement:

- *I understand that I am responsible for payment of my contracted fee with Spanish Montessori Learning Centre for as long as the contract remains in effect. I must give 1-month notice to terminate care or am responsible to pay fees for that month.*

  I understand____(Initials)

- *I agree to pay my fees in advance, on or before the **first (1) day of each month.** Fees will be paid in automatic withdrawal or with post-dated cheques. If payment is not received by the end of the **first (1) day**, the child/children will no longer be able to attend the program. Contract and care will be terminated at this time.*

  I understand____(Initials)

- *I agree that I am responsible to pay a late fee of $30 if the program fee is not received by the first business day of the month.*

  I understand____(Initials)

- *I will pay a $30 service charge for any NSF cheques. I understand that NSF cheques must be replaced with cash, debit, or a money order.*

  I understand____(Initials)

- *I will be required to pay monthly fees in order to reserve my child/children's space in the center if away for an extended period.*

  I understand____(Initials)

Are you currently subsidized or will you be applying to Alberta Child and Family Services? ☐ *Yes* ☐ *No*

- *I am responsible for ensuring that my child/children meet the number of hours required by Child and Family Services. If I do not meet these hours, I understand that I am responsible for unpaid fees.*

  I understand____(Initials)

- *If for any reasons, Child and Family Services reduces or eliminates my subsidy fees, I am responsible for unpaid fees.*

  I understand___(Initials)

I acknowledge the terms of this agreement and agree to them.

________________________	__________________	_______________
Parent/Legal Guardian Name (Print)	Signature	Date (YYYY-MM-DD)