

# Grunthal Christian Preschool

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Registration form

## Grunthal Christian Preschool

**2023/2024 preschool year**

*Please choose 1<sup>st</sup> choice class and 2<sup>nd</sup> choice class*

*We will do our best to get you into your first choice of class*

**Children must be potty trained (if your child has special needs or behavior concerns please talk to the Preschool Director)**

### Year born

(2020, 2019, 2018) Monday/Wednesday 3 / 4 yrs. AM \_\_\_\_\_ (Split 3 & 4class)

(2020, 2019, 2018) Monday/Wednesday 3 / 4's PM \_\_\_\_\_ (Split 3 & 4 class)

(2019 to 2018) Tuesday/Thursday 4 yrs. AM \_\_\_\_\_

(2019 to 2018) Tuesday/Thursday 4 yrs. PM \_\_\_\_\_

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**Child's Name:** \_\_\_\_\_ (Male \_\_\_\_\_ Female \_\_\_\_\_)

**Birthdate:** \_\_\_\_\_

(month/day/year)

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

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

City/Town: \_\_\_\_\_ Postal Code: \_\_\_\_\_

### Parents/guardians:

**Mother's Name:** \_\_\_\_\_ **Mother's phone:** \_\_\_\_\_

Mother's place of employment: \_\_\_\_\_ Phone: \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ **Father's phone:** \_\_\_\_\_

Father's place of employment: \_\_\_\_\_ Phone: \_\_\_\_\_

**Main Email address:** \_\_\_\_\_

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**Please check:** Married ( ) Separated ( ) Divorced ( ) Single ( ) Common-law ( )

**PARENT DESIGNATE:** Who may be contacted in the event of an emergency if BOTH Parents are not available.

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Is this child in the care of a foster agency? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of agency: _____
Name of social Worker: _____
Office address: _____
City: _____ Postal Code: _____
Phone: _____ Fax: _____

Names of individuals to whom your child may be released for pick-up from Preschool:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you give permission for your child to be photographed or videotaped? (Only for in class use)

YES \_\_\_\_\_ NO \_\_\_\_\_

Signature of Parent/guardian: \_\_\_\_\_

Date: \_\_\_\_\_

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## Medical Consent Form

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

MEDICAL CONDITIONS: please list any physical, developmental or emotional conditions relevant to the care of your child.

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Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Manitoba Health Family ID#: \_\_\_\_\_

Manitoba Health Individual 9-digit #: \_\_\_\_\_

Child's allergies: \_\_\_\_\_

*In the event of an emergency and I or my designated emergency contact are unable to be reached, I do give permission for a representative of the **Grunthal Christian Preschool** to take my child to hospital or clinic for treatment.*

Parents/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Social Worker Signature (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

## Parent Child Custody

Family Services requires GCP to have a copy of any court documentation regarding **child custody**. If this applies to your circumstances please make sure the appropriate paper work is attached.

\_\_\_\_\_ NO, this does not apply to our family

\_\_\_\_\_ Yes, this applies to our family and the appropriate documents will be in place for Sept.

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## Medical Questionnaire

Child's Name: \_\_\_\_\_

Please complete the following, Specify Yes if Doctor diagnosed

1. Life Threatening Allergies YES\_\_\_\_ NO\_\_\_\_  
If YES please specify allergy/allergies:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. EpiPen/auto-injector prescribed. YES\_\_\_\_ NO\_\_\_\_
3. EpiPen /auto-injector provided to centre. YES\_\_\_\_ NO\_\_\_\_
4. Asthma YES\_\_\_\_ NO\_\_\_\_
5. Inhaler provided to School YES\_\_\_\_ NO\_\_\_\_
6. Bleeding Disorder YES\_\_\_\_ NO\_\_\_\_
7. Diabetes YES\_\_\_\_ NO\_\_\_\_
8. Heart Condition YES\_\_\_\_ NO\_\_\_\_
9. Seizure Condition YES\_\_\_\_ NO\_\_\_\_
10. Other significant conditions that are Physician diagnosed (i.e. Ulcerative Colitis, Crohns, Transplants, Spina Bifida, Permanent physical limitations).  
\_\_\_\_\_  
\_\_\_\_\_

**This medical information is being collected so that appropriate individual health care plan may be developed. The Grunthal Christian Preschool will share the above information with URIS (unified referral and intake system) if your child has anaphylaxis or severe medical condition. The program is a partnership between, Health, Family Services and Housing, Education and Youth.**