



**WESTMOUNT CHARTER SCHOOL
APPLICATION FOR KINDERGARTEN**

728 32 St NW
Calgary, AB T2N 2V9
(403) 217-0426

Email: registrar@westmountcharter.com

Principal
Dr. Shelley Robinson
Assistant Principals
Marylyn Waters
Hal Curties
Dani Sever
Chris Hooper

SCHOOL INFORMATION DISCLOSURE

The information requested on this form is collected under the *School Act* (Student Record Regulation), Alberta's *Freedom of Information and Protection of Privacy (FOIP) Act*, and the *Canadian Charter of Rights and Freedoms*, Section 23. Information acquired through this form is kept secure and access is restricted. (If you have any questions regarding the collection, use or disclosure of this information, please contact the school administration.)

STUDENT INFORMATION

LEGAL LAST NAME:	LEGAL FIRST NAME:	LEGAL MIDDLE NAME:

LAST NAME (IF DIFFERENT FROM ABOVE)	FIRST: (IF DIFFERENT FROM ABOVE)	GENDER: FEMALE <input type="radio"/> MALE <input type="radio"/>

BIRTHDATE: MONTH DAY YEAR	SIBLINGS ATTENDING WESTMOUNT : NAME	GRADE (SEPT 2012)

Please note: children born later than February 28, 2008 are not eligible for Kindergarten in the 2012-2013 school year.

FRANCOPHONE ELIGIBILITY: Does your child have Francophone eligibility? NO <input type="radio"/> YES <input type="radio"/> If yes and you wish to exercise your right to have your child educated in a Francophone School, please contact the Conscils Scolaires Catholique et Francophones de sud e l'Alberta phone (403) 685- 9881.		
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CLASS PREFERENCE. Class assignments are on a first come, first served basis. We cannot guarantee your first choice.

Full days - Monday/Wednesday/Friday Full days - Tuesday/Thursday/Friday* No preference

**a schedule will be provided indicating your designated Fridays*

CITIZENSHIP: CANADIAN LANDED IMMIGRANT OTHER

A copy of the student's Birth Certificate must be attached in order for this application to be processed. If the student was not born in Canada, a copy of the immigration documentation must also be attached; ideally this would be a Permanent Residency Card or Canadian Passport.

A copy of immunization records, if available, should also be attached.

If you wish to declare that you are an Aboriginal person, please contact the office for further details and clarification.

PRESCHOOL, SCHOOL OR CARE AGENCY ATTENDED

NAME OF PRESCHOOL, SCHOOL OR CARE AGENCY:	ADDRESS:
PHONE: FAX:	CITY: PROV: POSTAL CODE:

I hereby give permission to Westmount Charter School to contact the above named school, preschool or care agency for the purpose of requesting student records and making inquiries of previous teachers and administrators regarding information that may be pertinent to student programming.

Or check here if your child has not attended such a program

_____ _____
PARENT / GUARDIAN SIGNATURE DATE

PARENT/GUARDIAN INFORMATION

STUDENT LIVES WITH (INFORMATION COLLECTED TO ENABLE SCHOOL TO DIRECT COMMUNICATIONS TO APPROPRIATE ADDRESS(ES))

MOTHER & FATHER MOTHER FATHER LEGAL GUARDIAN OTHER (please specify) _____

**WESTMOUNT CHARTER SCHOOL
ADMINISTRATION OF PRESCRIPTION MEDICATION AND/OR MEDICAL TREATMENT FORM**

[To be completed ONLY if your child has a severe allergy or medical condition that will require treatment and/or administration of medication at school. If this is NOT the case please do not fill out this form]

Student Information

Student's Name: _____ Grade/Class: _____

Student's Alberta Health Care Number: _____ Student's Date of Birth: _____

Home Address: _____

Contact Information

Mother's Name: _____ Father's Name: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Emergency Contact Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

Severe Allergy Alert Information

This portion of the form should be completed only if the student has a severe allergy. A severe allergy is defined as a severe allergic reaction or anaphylactic response which, if left untreated, can lead to sudden death.

Allergen(s): _____

Symptoms of a reaction: _____

Emergency Action Plan: *(attach separate sheet if needed)* _____

Medication/Treatment Information

Medication prescribed: _____

Purpose of medication: _____

Medication dosage, time of administration and procedure for administration: _____

Medication storage and safekeeping requirements: _____

Specifics of treatment required, if any: _____

Medication/Treatment Information (cont.)

Possible side effects of medication(s)/treatment and remedial action for side effects: _____

Will it be detrimental to the student's health if a single dose/treatment is omitted? Yes No

Must this student have this medication/treatment administered during school hours in order to be able to attend school? Yes No

Self-Administration Information

Is this student able to administer his/her own medication/treatment? Yes No

If yes, provide details: _____

Charter Board policy requires that, except in emergencies, the student shall self-administer under adult supervision.

Informed Parental Consent and Acknowledgement

I am the parent of the student named above ("my child") and I acknowledge and agree:

1. I will provide an adequate and fresh supply of medication for my child.
2. I understand the medication will be stored in a secure location and administered by school staff unless I have given consent for my child to self-administer the medication.
3. I understand it is my responsibility to advise school staff of any change in my child's medical condition or medication.
4. I acknowledge that actions taken by school personnel will be limited to what is possible in a school setting, and to what can be done by persons untrained in medical procedures.
5. If any emergency arises, I authorize school personnel to administer medication and/or secure medical advice and services, including calling paramedics as deemed necessary. I agree to be financially responsible for such emergency medical assistance.
6. By signing this form, I consent to and authorize school personnel to administer medication/medical treatment to my child.
7. I understand that the Charter Board fully accepts responsibility for students under its care, and is liable to the parents and the students for any loss, injury or damages which occur as a result of the negligence of the school. I am fully aware that there are risks and hazards associated with the administration of medication or medical treatment and that my child may suffer bodily injury as a result of these risks and hazards, and my child may suffer personal and potentially serious injury due to an unforeseeable or fortuitous event.
8. **This form is valid only for the school year in which it is submitted.**

Date: _____ Name of Parent: _____ Signature: _____

Physician's Endorsement

1. The information provided on this form is accurate and complete.
2. The assistance of school personnel required to administer this medication and/or medical treatment is within the competence of persons untrained in medical procedures.

Date: _____ Name of Physician: _____ Signature: _____