

# LEAPS & BOUNDS EARLY LEARNING CENTRE

## OUT OF SCHOOL CARE REGISTRATION FORM

Registration Fee Yes  No

CHILD'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ (YYYY/MM/DD)

<i>(For Office Use Only)</i>	START DATE: _____ / ____ / ____
<i>(For Office Use Only)</i>	TERMINATION DATE: _____ / ____ / ____ YYYY MM DD
<i>(For Office Use Only)</i>	Room: _____
Full Fees: _____	Subsidy: _____ Parent: _____
Moved From Rm: _____	To: _____ Date: _____

**MOTHER'S NAME:** \_\_\_\_\_

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

Cell #: \_\_\_\_\_

Res. Phone #: \_\_\_\_\_

**EMAIL Address:** \_\_\_\_\_

Place of Work: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Work Timings: \_\_\_\_\_

**FATHER'S NAME:** \_\_\_\_\_

Address: *(If Different)* \_\_\_\_\_  
\_\_\_\_\_

Cell #: \_\_\_\_\_

Res. Phone #: \_\_\_\_\_

**EMAIL Address:** \_\_\_\_\_

Place of Work: \_\_\_\_\_

Work Phone #: \_\_\_\_\_

Work Timings: \_\_\_\_\_

**Emergency Contact who lives in EDM (Excluding Parents)**

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

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

Main Phone Contact #: \_\_\_\_\_

Relationship: \_\_\_\_\_

**Child's Physician:**

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

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

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

Alberta Health Care #: \_\_\_\_\_

Marital Status: Single  Married  Separated

Divorced  Widowed

**Authorized Person(s) To Whom Child May Be Released:**

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

Relationship: \_\_\_\_\_

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

Relationship: \_\_\_\_\_

Other Children In the Family (Names):

Age

School/Day Care/Other

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PLEASE NOTE:** It is your responsibility to inform the Director whenever there is a change in any information provided above.



# Leaps & Bounds

## Early Learning Centre