Registration Form

Start Date: _____ Class Time: _____

End Date: _____ Days: _____

Location: _____

1. STUDENT INFORMATION

Last Name:	First Name:	Middle Name:
Usual Name if different from above:	Date of Birth:	Gender:
Childs Home address:		Childs Home Phone number:

2. STUDENT INFORMATION

Last Name:	First Name:	Middle Name:
Usual Name if different from above:	Date of Birth:	Gender:
Childs Home address:		Childs Home Phone number:

Parent/Guardian Information. **Circle Primary Contact: Mother Father Guardian**

Mother's Name:	Mobile Number:
Email:	Home Phone:
Mothers Work Place:	Work Phone:
Home Address:	
Father's Name:	Mobile Number:
Email:	Home Phone:
Fathers Work Place:	Work Phone:
Custody Agreement: Yes ☐ /No ☐ IF YES, PLEASE PROVIDE A COPY OF THE CUSTODY ORDER	

Person(s) Authorized to Pick up Child (Other than Parent / Guarding Listed Above)

Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:

Alternative Person(s) to Call in Case Emergency

Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:

Out of Province Contact

Please list at least one out of province contact. Note: this person will be contacted if there are no local services available due to natural Disasters

Name:	Relationship:	Phone Number:
Name:	Relationship:	Phone Number:

Emergency Health Information

Care Card Number:		
Family Physician:	Phone Number:	Clinic Name & Address:
Family Dentist:	Phone Number:	Clinic Name & Address:

Consent for Emergency Care

In the event that my child _____ is injured, ill, or in need of immediate medical attention, I, _____, Authorize the staff of First Choice Montessori Academy to seek medical attention and/or admit my child to hospital if I am unable to be contacted or otherwise unable to respond

Signature of Parent/Guardian _____ Date: _____

Childs Immunization Record (Please record dates [year/month/date] or attach copy of immunizations

DIPTHERIA	PERTUSSIS	TETANUS	POLIO	MMR	HIB
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
Comments:					

Health Information

Does your child have any life threatening allergies	YES ☐	NO ☐
Please list all Allergies or medical concerns your child may have		
Developmental Area	YES ☐	NO ☐
Speech or language development	YES ☐	NO ☐
Physical development	YES ☐	NO ☐
Hearing	YES ☐	NO ☐
Vision	YES ☐	NO ☐
Dental	YES ☐	NO ☐
Is your child taking any medication	YES ☐	NO ☐
- If yes, please describe:		
Has Your child attended preschool or daycare before	YES ☐	NO ☐
- If yes, please list the name of the school and how long he/she attended		

Signature of Parent/Guarding providing information

Print Name:_____Signature: _____ Date signed: _____

PARENT AGREEMENT

I, THE UNDERSIGNED, AGREE TO THE FOLLOWING:

1. To enroll _____ at First Choice Montessori for the _____ school year.

2. Upon registration there is a $100.00 non-refundable registration fee due for all students.

3. To issue all the postdated cheques prior to enrolling my child.

4. Should I have the need to withdraw my child from First Choice Montessori Academy during the school year. I understand that the school needs to be provided with **one month's written notice** of withdrawal or one months fee in lieu of one month's written notice. First Choice Montessori does not except any written notices as of the start of the last school term (April 30,____). If you withdraw from First Choice Montessori Program after April 30, ____ the remaining monthly fee's are still payable.

5. The school has a right to release your child under certain circumstances and in this case and this case only there will be a refund of that months tuition.

6. To deliver my child directly to a staff member, and not to take my child without informing a staff member.

7. To be on time when dropping off and picking up my child.

8. To notify the school in writing and in advance if any person other than the undersigned or emergency contact is picking up my child.

9. If my child is sick, he/she must stay at home. I understand children with contagious/ communicable illnesses should not attend school. If my child becomes sick while he/she is at school, I will be contacted and will be asked to take my child home for the day and remain at home until he/she is symptom free. If the school is unable to contact the parent/ guardian, the alternate authorized person(s) provided on the registration form will be contacted. I understand children should be kept at home if there is any question of illness and the school should be notified of the nature of the illness.

10. That permission is granted to call a physician or ambulance in case of an accident.

11. As a parent/guardian it is my responsibility to keep the school informed of an changes in home address, phone number, emergency contact, person(s) authorized for picking up, allergies etc...

12. Our holidays for each break that are within the public schools align with the school's closure times. For our daycare facilities, the closures will be as follows: all statutory holidays, one week in December, one week in March, and one week in August. All parents will be informed at the beginning of that school year and closer to those months.

13. I allow the staff of First Choice Montessori Academy to take my child for community walks in the neighbourhood.

14. I allow the staff of First Choice Montessori Academy to take pictures/videos of my child during class program hours and other special events to display on the First Choice Montessori website and social media platforms.

15. That First Choice Montessori Academy is not responsible in any way for any hann my child may suffer as a result of non-negligent behaviour by any staff member or as a result of an uncontrolled event or action taken by the child him/herself, or any other individual or by an act of God.

I have read and fully understand the First Choice Montessori Academy enrolment form, and agree to abide by the terms and conditions.

Signature of Parent/Guarding providing information

Print Name:_____Signature: _____ Date signed: _____

Medical Consent Form

It is the policy of this centre to notify a parent when a child is ill or needs medical • attention. Occasionally we cannot contact parents and we need to get immediate help for the child Our procedure is to ensure that the child is taken to the nearest emergency service.

Please sign the consent below so that the facility staff can take appropriate action on behalf of your child This consent will accompany the child to the emergency centre.

I hereby give consent for my child _____ when ill to be taken to the nearest emergency centre by emergency vehicle when I cannot be contacted. Any associated cost incUlTed as a result of emergency transportation or medical treatment for the child is the responsibility of the child's parents/guardian.
I hereby consent for my child _____ to receive medical treatment

Signature of Parent/Guarding providing information

Print Name:_____Signature: _____ Date signed: _____

PAYOR‘S PAD AGREEMENT

INSTRUCTIONS

1. The Payee must retain this agreement for at least 12 months after the last Pre-Authorized Debit (PAD) is issued.
2. The Payee can obtain the transaction type code form the CPA‘s website: http://www.cdnpay.ca/rules/pdfs_rules/standard_005.pdf.
3. The Payee will insert the number of days required to cancel a payment in the ‚Cancel Payment‘ Section (cannot exceed 30 days).

PAYOR INFORMATION

Account Holder Name(s) (the ‚Payor‘)

Surname First Name(s)

eMail Address

Phone Number

Address

Street

City, Province

Postal Code

PAYEE INFORMATION

PAYMENT DETAILS ◯ *Specimen cheque marked ‚VOID‘ attached.*

Description of PAD *(optional)*	**CPA Transaction Type Code**	**Payment Type** *(choose one only)* ◯ Personal PAD ◯ Business PAD ◯ Funds Transfer PAD	**Payor financial Institution Name** *(the ‚Processing Institution‘)*
Amount of Payment ◯ Fixed $ _____ ◯ Variable *(max. amount):* $	**Dates** ◯ Weekly beginning _____ ◯ Bi-weekly beginning _____ ◯ Monthly beginning _____		**Payor financial Institution Address** *(the ‚Processing Institution‘)*
Payor Account *(The Payor‘s account at the Processing Institution; the ‚Account‘)*			
Institution No.	**Branch ID**		**Account No.**

AUTHORIZATION

I/We acknowledge that this agreement is provided for the benefit of the ‚Payee‘ and ‚Processing Institution‘ and is provided in consideration of the Processing Institution agreeing to process debits (‚PADs‘) against the Account with the Processing Institution in accordance with the Rules of the Canadian Payment Association (the ‚CPA Rules‘). By signing this agreement, the Payor acknowledges having received and having read a copy of this agreement, including the terms and conditions on page 2, acknowledges understanding the terms and conditions of this agreement, and agrees to be bound by the terms and conditions of this agreement, including the terms and conditions on page 2. I/We warrant and guarantee that the person(s) whose signature(s) are required to sign on the Account have signed the agreement.

x _____ x _____

Payor Signature, Date Payor Signature, Date

WAIVER OF PRE-NOTIFICATION

I/We waive any and all requirements for pre-notification of debiting, including, without limitation, pre-notification of any changes in the amount of the PAD due to a change in any applicable tax rate, top-up, or adjustment.

x _____ x _____

Payor Signature, Date Payor Signature, Date

CANCEL PAYMENT *(___ Days notice is required before the next PAD will be issued. Cannot exceed 30 days.)*

The Payor hereby cancels this Payor‘s PAD Agreement effective:

x _____ x _____

Payor Signature, Date Payor Signature, Date

PAYOR'S PAD AGREEMENT

TERMS AND CONDITIONS

1. I/We hereby authorize the Payee, in accordance with the terms of my/our account agreement with the Processing Institution, to debit or cause to be debited the Account for the purposes indicated in the "Payment Type" section on page 1 of this agreement.

Particulars of the Account that the Payee is authorized to debit are indicated in the "Payment Details" section on page 1 of this agreement. A specimen cheque, if available for the Account, has been marked "VOID" and attached to this agreement.

2. I/We undertake to inform the Payee, in writing, of any change in the Account information provided in this agreement prior to the next due date of the PAD.
3. This agreement is continuing but may be cancelled at any time upon notice being provided by me/us, either in writing or orally, with proper authorization to verify my/our identity within the specified number of days before the next PAD is to be issued as noted on Cancel Payment section, Page 1. I/we acknowledge that I/we can obtain a sample cancellation form or further information on my/our right to cancel this agreement from the Processing Institution or by visiting www.cdnpay.ca. I/we acknowledge that if I/we wish to cancel this agreement or if I/we have any questions or need further information with respect to a PAD, I/we can contact the Payee at the telephone number or address set out in this agreement.
4. Revocation of this agreement does not terminate any contract for goods or services that exists between me/us and the Payee. This agreement applies only to the method of payment and does not otherwise have any bearing on the contract for goods or services exchanged.
5. I/We acknowledge that provision and delivery of this agreement to the Payee constitutes delivery by me/us to the Processing Institution. Any delivery of this agreement to the Payee constitutes delivery by the Payor.
6. If this agreement is for fixed or variable amount business, personal, or funds transfer PADs recurring at set intervals, unless I/we have waived any and all requirements for pre-notification of debiting in the "Waiver of Pre-Notification" section on page 1 of this agreement, or unless the change in the amount of any such PAD will occur as a result of my/our direct action (such as, but not limited to, telephone instructions or other remote measures), I/we acknowledge that I/we will receive:
   a) with respect to fixed amount business or personal PADs, written notice from the Payee of the amount to be debited and the due date(s) of debiting, at least 10 calendar days before the due date of the first PAD, and such notice will be received every time there is a change in the amount or the payment date(s); or
   b) with respect to variable amount business or personal PADs, written notice from the Payee of the amount to be debited and the due date(s) of debiting, at least 10 calendar days before the due date of every PAD; or
   c) with respect to business, personal, or funds transfer PADs, at least 10 calendar days' written notice from the Payee of any change in the amount of the PAD which results from a change in any applicable tax rate, a top-up, or other adjustment. No pre-notification will be given if the amount of the PAD decreases as a result of a reduction in munici pal, provincial, or federal tax.

   Pre-notification may be given in writing or in any form of representing or reproducing words in visible form, which, if I/we have provided an email address to the Payee, includes an electronic document. The amount of pre-notification provided will change when there is a change in the pre-notification requirements contained in the CPA Rules.
7. If this agreement provides for PADs with sporadic frequency, I/we understand that the Payee is required to obtain an authorization from me/us for each and every PAD prior to the PAD being exchanged and cleared. I/we agree that a password or security code or other signature equivalent will be issued and will constitute valid authorization for the Processing Institution to debit the Account.
8. I/We acknowledge that the Processing Institution is not required to verify that a PAD has been issued in accordance with the particulars of this agreement, including, but not limited to, the amount.
9. I/We acknowledge that the Processing Institution is not required to verify that any purpose of payment for which the PAD was issued has been fulfilled by the Payee as a condition to honouring a PAD issued or caused to be issued by the Payee on the Account.
10. I/We acknowledge that, if this agreement is for personal or business PADs or for funds transfer PADs that have recourse through the clearing system, a PAD may be disputed under the following conditions:
    a) the PAD was not drawn in accordance with this agreement;
    b) this agreement was revoked; or
    c) pre-notification was required and was not received.

    I/We further acknowledge that in order to be reimbursed, a declaration to the effect that either a), b), or c) took place must be completed and presented to the branch of the Processing Institution holding the Account on or before the 90th calendar day in the case of a personal PAD or a funds transfer PAD that has recourse through the clearing system or, in the case of a business PAD, on or before the 10th business day, in each case after the date on which the PAD in dispute was posted to the Account.
11. I/We acknowledge that any claim made after the periods set out above must be resolved solely between me/us and the Payee and there is no entitlement to reimbursement from the Processing Institution.
12. I/We acknowledge and agree that if this agreement is for funds transfer PADs and the Payee does not provide recourse through the clearing system, then no recourse will be provided through the clearing system (that is, I/we will not receive automatic reimbursement in the event of a dispute) and I/we must seek reimbursement or recourse from the Payee in the event a PAD is erroneously charged to the Account.
13. Unless this agreement is for a funds transfer PAD that does not have recourse through the clearing system, I/we acknowledge that I/we have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD agreement. To obtain more information on my/our recourse rights I/we can contact my/our financial institution or visit www.cdnpay.ca.
14. I/We acknowledge that I/we understand that I/we am/are participating in a PAD plan established by the Payee and I/we accept participation in the PAD plan upon the terms and conditions set out herein.
15. I/We consent to the collection, use, and disclosure of any personal information that may be contained in this agreement to the financial institution that holds the account of the Payee to be credited with the PAD to the extent that such disclosure of personal information is directly related to and necessary for the proper application of Rule H1 of the Rules of the Canadian Payments Association.

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EMERGENCY CONSENT CARD

_____
Name of Facility

Child's Name: _____ **Birthdate:** _____
Surname First Name(s) Year / Month / Day

Address: _____ **Gender of Child:** _____

_____

1. Parent's Name: _____ **Child lives with:** _____

Work Phone: _____ **Home Phone:** _____

2. Parent's Name: _____

Work Phone: _____ **Home Phone:** _____

Emergency Contact: _____ **Phone:** _____

Child's Doctor: _____ **Phone:** _____

1. Allergies _____

2. Medications _____

Care Card #: _____

PrintShop #252700 Revised August 2019

CONSENT FORM

It is the policy of this centre to notify a parent when a child is ill or needs medical attention. In the event we cannot contact you and we need to get immediate help for your child, we require a signed consent to do so.

1. I give consent for my child to be taken to the nearest emergency medical centre when I cannot be contacted.
2. I give consent for my child to receive medical treatment.

_____
Signature of Parent/Guardian

Picture of Child

_____
Witness

_____
Date

Personal information contained on this form is collected under the Community Care and Assisted Living Act and will be used only for the purpose indicated.

fraserhealth

EMERGENCY CONSENT CARD

_____
Name of Facility

Child's Name: _____ Birthdate: _____
Surname First Name(s) Year / Month / Day

Address: _____ Gender of Child: _____

_____

1. Parent's Name: _____ Child lives with: _____

Work Phone: _____ Home Phone: _____

2. Parent's Name: _____

Work Phone: _____ Home Phone: _____

Emergency Contact: _____ Phone: _____

Child's Doctor: _____ Phone: _____

1. Allergies _____

2. Medications _____

Care Card #: _____

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