Medicine Hat Catholic Board of Education
1251 — 1st Avenue SW, Medicine Hat, AB T1A 8B4
Phone: 403-527-2292 | www.mhcbe.ab.ca | Fax: 403-529-0917

PD DAY CHILD CARE PROGRAM REGISTRATION

STUDENT/FAMILY INFORMATION:

Legal Name:
(Last Name) (First Name) (Middle Name)
Street/Mailing Address (Legal land description if a P/O Box): _ City: _ Postal Code: Home

Phone: _

Date of Birth: Child's Age as of September 1st: Gender:
(Year/Month/Day)

Parent / Guardian	Parent / Guardian
Contact 1	**Contact 2**
Does the child reside with you? ☐ Yes ☐ No	Does the child reside with you? ☐ Yes ☐ No
Relationship to child: _____	Relationship to child: _____
Name:_____	Name:_____
Address (Legal land description if a P/O Box):	Address (Legal land description if a P/O Box):
_____	_____
City:_____Prov.:_____	City:_____Prov.:_____
Postal Code: _____	Postal Code: _____
Contact Numbers:	Contact Numbers:
Home:_____	Home:_____
Work:_____	Work:_____
Cell: _____	Cell: _____

MEDICAL INFORMATION:

Family Physician: Phone Number: Does your child have any allergies? ☐ Yes ☐ No (If you indicated yes, please explain and include severity):

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_ Are your child's immunizations up to date? ☐ Yes ☐ No
Does your child use any medication regularly? ☐ Yes ☐ No (If you indicated yes, please explain in detail):
Is there any other relevant health information? ☐ Yes ☐ No (If you indicated yes please explain in detail):

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EMERGENCY CONTACT INFORMATION:

In the event that a Parent/Guardian cannot be contacted, please list two alternate Emergency Contact persons:

Emergency Contact #1	**Emergency Contact #2**
Name:_____	Name:_____
Relationship to child: _____	Relationship to child: _____
Address: (Legal land description if a P/O Box)	Address: (Legal land description if a P/O Box)
_____	_____
City:_____Prov.:_____	City:_____Prov.:_____
Postal Code:_____	Postal Code:_____
Contact Numbers:	Contact Numbers:
Home:_____	Home:_____
Work:_____	Work:_____
Cell: _____	Cell: _____

DESIGNATED PICK-UP PERSON INFORMATION:

Person(s) other than Parent/Guardian or Emergency Contact authorized to PICK-UP child:

Pick-Up Person #1	**Pick-Up Person #2**
Name:_____	Name:_____
Relationship to child: _____	Relationship to child: _____
Contact Phone: _____	Contact Phone: _____

CUSTODY INFORMATION:

Please indicate whether a Parenting Order or Contact Order exists for your child. ☐ Yes ☐ No

***(If you indicated yes, legal documentation is required).**

FIRST-AID CONSENT:

I give my permission to the MHCBE PD Day Child Care Program Staff to
(Print Name)

administer medical attention in the nature of first-aid to my son/daughter
(Print Child's Name)

in the event of an emergency.

Signature: _ Date: _

MEDICINE HAT CATHOLIC BOARD OF EDUCATION PD DAY CHILD CARE PROGRAM PARENT AGREEMENT:

1. MHCBE PD Day Child Care Program assumes no liability or responsibility for anything that occurs because of false information provided at the time of registration. It is the parents' responsibility to inform the MHCBE PD Day Child Care Program Coordinator of any changes that occur after the original registration form was completed. (i.e., phone number, employment, emergency pick up, etc.).
2. Parents or designates must physically accompany their child into the designated program area for all drop-offs and pick-ups, ensuring their child is signed in and out of the program. Children will be released only to authorized persons as stated by the parents or guardians on the registration form. Children WILL NOT be released to anyone not on the registration form.
3. **Parents requiring scheduled care agree to provide the hours of care required to the MHCBE PD Day Child Care Program Coordinator as soon as possible. Parents are responsible for adhering to this schedule and will advise the MHCBE PD Day Child Care Program Coordinator of any changes to arrival and pickup times.**
4. In the event of a serious medical emergency, the supervisor will call 911 and then contact the parents or guardians. If a child is ill, the parent(s) or guardian(s) will be contacted and must pick up the child immediately. The MHCBE PD Day Child Care Program reserves the right to engage emergency medical assistance for any child left in its care, when such assistance is deemed to be necessary. The expense of the required assistance to be borne solely by the parents or guardians of the child.
5. The parents agree to pay according to the attached fee schedule. Please note fees are subject to change. **Service will be canceled for those who fail to pay**.

I have seen, read and agree with the above outlining my responsibilities to the MHCBE PD Day Child Care Program

We, the undersigned being the parents and/or legal guardians of_____ (name of child) hereby certify that we have given careful consideration to the participation by our son/daughter in the MHCBE PD Day Child Care Program and understand fully the nature and character of the risk undertaken by our son/daughter and agree to accept on behalf of the same child, all risks and responsibilities for injury or damage beyond the control of the MHCBE PD Day Child Care School Program. We further certify, we are hereby releasing the MHCBE PD Day Child Care School Program, School Administration, and the Medicine Hat Catholic Board of Education and their sub-agents from all claims and demands whatsoever, occurring as a result of damage incurred to the child by reason of activities outside of the authority extended by the MHCBE PD Day Child Care School Program in the conduct of this project. I consent to the MHCBE's PD Day Child Care School Program sharing information with teachers and staff of the School as needed about my child.

Please note: Any changes, either removal from the program, or monthly changes to your scheduled days must be submitted by the 15th of the previous month (e.g. Changes for the month of January must be made in writing to the office by Dec 15th) otherwise the full month fee will be required. Please Initial

_____

_____ _____

Parent/Guardian #1 Signature Date

_____ _____

Parent/Guardian #2 Signature Date

_____ _____

MHCBE PD Day Child Care Representative Signature Date

Start Date:_____

Applying for Provincial Subsidy: ⬜ Yes ⬜ No **Please inform the school office if you are applying.**

FEE SCHEDULE AND SESSION TIMES: * PD Day Childcare Specific

This schedule is based on the child attending P.D. Day Child Care ($50.00/ scheduled P.D. Day). This allows the fee to remain the same price each month.

A reminder that there is NO drop-in price available. The program will run from 8:00 am to 5:00 pm. Parents MUST register and remit funds for the specific PD Day, by the 15th of the previous month, for example if you require care for September 23, 2022, you will be required to register and pay by August 15, 2022. **It is the parents' right to not utilize all of the days they have registered for, but if a day is missed without prior notice (by the 15th of the previous month), refunds will not be available**.

There is a Daily Registration Fee of **$50.00 (per child)** which will be billed separately than your regular Out of School Care Fee.

Please place a checkmark (✔) in the slot(s) that you require for the MHCBE PD Day Child Care Program.

Licencing regulations require us to have this information on file.

PD Day Child Care Schedule

All PD Days 830 a.m. – 5:30 p.m.	
Friday September 23, 2022	
Friday October 7, 2022	
Monday November 7, 2022	
Tuesday November 8, 2022	
Wednesday November 9, 2022	
Thursday November 10, 2022	
Friday December 23, 2022	
Tuesday January 3, 2023	
Wednesday January 4, 2023	
Thursday January 5, 2023	
Friday January 6, 2023	
Friday January 20, 2023	
Tuesday February 21, 2023	
Wednesday February 22, 2023	
Thursday February 23, 2023	
Friday February 24, 2023	

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Friday March 17, 2023	
Tuesday April 11, 2023	
Wednesday April 12, 2023	
Thursday April 13, 2023	
Friday April 14, 2023	
Friday April 28, 2023	
Monday May 29, 2023	

Payment information will be sent out in August 2022