# Queen of Angels

# Out of School Care Program

## Kindergarten – Grade 6 Students

Licence # 1381622

# 2023-2024

Please attach a recent photo of your child.

# Angel Care Out of School Program (OSC)

## Kindergarten – Grade 6

# 2023-2024 School Year Fee Schedule

Our Program is a registered participant in the BC Child Care Fee Reduction Initiative (CCFRI)
Students kindergarten through 12 years of age qualify for a fee reduction under this program
*Fee reduction will be calculated and applied to Family Payment Schedule

## Full-Time Out of School Care - $280.00 per month

(Includes early dismissal days)

### DROP-IN RATES

Drop-In Rate - $17.00 per day

2:00pm Early Dismissal Day Drop-In Rate - $22.00 per day

12:00pm Early Dismissal Day Drop-In Rate - $25.00 per day

*Drop-in fees are due upon pick-up of student*

### PRO-D DAYS & CAMPS

Pro-D Day - $40.00 per day

Christmas & Spring Break Camps - $225.00 per week

(Being offered 1 week at Christmas & 2 weeks at Spring Break)

**Late Pick-up Fee: $1 for each minute after program closure (OSC closes @ 5:30pm).**

A **$30.00** non-refundable registration fee is required at the time of application for registration.

All fees are divided into 10 equal payments. There are no reductions for shorter months or holidays.

A minimum of one month's written notice is required for withdrawal from our Child Care Centre.

Upon acceptance to our Child Care Centre, a Family Payment Schedule must be signed, and a direct debit form or void cheque must be on file at the school office.

We ask children to bring a pair of indoor shoes with non-marking soles to remain at the Angel Care Out of School Care for their daily use, as well as an after-school snack.

# Angel Care Child Care Centre
# Out of School Care Program

2085 Maple Bay Rd., Duncan, BC, V9L 5L9
Phone: (250) 701-0433
Email: angelcare@cisdv.bc.ca

## REGISTRATION FORM

**ALL INFORMATION MUST BE COMPLETE PRIOR TO ACCEPTANCE OF APPLICATION FOR REGISTRATION**

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Our Program is offered on a full-time or drop-in basis, September – June.
Please check off the applicable type of care you require for our 2023-24 program year:

☐ **Full-time OSC (Monday – Friday, pick up by 5:30pm)**

☐ **Drop-in (Based on space availability)**

Start Date: ______________________________

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**STUDENT's Information** - Name: ______________________________________ ☐ M ☐ F
First / Middle / Last

Date of Birth: ______/______/______ Name child responds to: ________________________
Day / Month / Year

Street Address: ____________________________________________________________

Mailing Address: ___________________________________________________________

Person(s) with whom the child lives (include siblings): ______________________________

____________________________________________________________________________

Primary language spoken at home: ______________ Secondary language: ______________

**MOTHER's Information** - Name: ___________________________________________

Address: ____________________________________________________________

Occupation: ___________________ Email: __________________________________

(Please print clearly)

Phone – Home: ________________ Cell: _______________ Work: ________________

**FATHER's Information** - Name: ____________________________________________

Address: ____________________________________________________________

Occupation: ___________________ Email: __________________________________

(Please print clearly)

Phone – Home: ________________ Cell: _______________ Work: ________________

**Authorization for Pick-up (other than Parents/Guardians):**

Name: ______________________ Home Phn: ______________ Cell: ______________

Name: ______________________ Home Phn: ______________ Cell: ______________

Name: ______________________ Home Phn: ______________ Cell: ______________

Name: ______________________ Home Phn: ______________ Cell: ______________

Parent/Guardian Signature for consent to release a child to someone other than a parent:

X ___________________________________________

**Is there anyone who is not permitted to pick-up under any circumstances?**

*If this is a parent with limited or restricted guardianship, Court Documents are required for our records.

Name: ________________________________ Relationship to Child: ______________

Name: ________________________________ Relationship to Child: ______________

Custody Agreement details (if any) that you wish us to be aware of: **(Attach supporting documents)**

______________________________________________________________________

______________________________________________________________________

**Alternate Emergency Contacts (please provide two):**

Name: __________________________________ Relationship: ___________________

Phone – Home: ________________ Cell: _______________ Work: ________________

Name: __________________________________ Relationship: ___________________

Phone – Home: ________________ Cell: _______________ Work: ________________

**HEALTH Information:**

To best support our students, it is important that our Centre has a full understanding of a child's needs. Does your child have any of the following in place with the school?

☐ IEP (Individualized Education Plan)

☐ Any other form of a support plan

If yes, please sign below to authorize Queen of Angels to share this confidential information with our Angel Care Child Care Centre.

| ______________________________ | ______________________________ | ______________________________ |
|---|---|---|
| Signature of Parent/Guardian | Name (Please Print) | Date |

**Does your child:**

| | | | | | |
|---|---|---|---|---|---|
| Have speech/language challenges? | ☐ Yes | ☐ No | Have any allergies? | ☐ Yes | ☐ No |
| Have vision challenges? | ☐ Yes | ☐ No | Require a special diet? | ☐ Yes | ☐ No |
| Have hearing challenges? | ☐ Yes | ☐ No | Take medications? | ☐ Yes | ☐ No |
| Have other health concerns? | ☐ Yes | ☐ No | Have physical restrictions? | ☐ Yes | ☐ No |

***Specify/Comment on items ticked "Yes":** ______________________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Does your child have any behaviour concerns? ______________________________________

________________________________________________________________________________

Is there anything else you would like us to know about your child? ___________________

________________________________________________________________________________

________________________________________________________________________________

Please list any illnesses, or communicable diseases your child has had: ________________

________________________________________________________________________________

**IMMUNIZATION Information** – Please either attach a photocopy of immunization record, OR indicate the dates on which immunizations were received below.

## Basic Schedule and Record of Immunizations as submitted by Parent or Guardian

| **1st visit – 2 months of age:** | **Date (yy/mm/dd)** |
|---|---|
| Diphtheria | ________________________________ |
| Pertussis | ________________________________ |
| Tetanus | ________________________________ |
| Polio | ________________________________ |
| Haemophilus Influenzae Type b (Hib) | ________________________________ |
| Hepatitis B | ________________________________ |
| Pneumococcal Conjugate | ________________________________ |
| Meningococcal C Conjugate | ________________________________ |

| **2nd visit – 2 months after 1st visit:** | **Date (yy/mm/dd)** |
|---|---|
| Diphtheria | ________________________________ |
| Pertussis | ________________________________ |
| Tetanus | ________________________________ |
| Polio | ________________________________ |
| Haemophilus Influenzae Type b (Hib) | ________________________________ |
| Hepatitis B | ________________________________ |
| Pneumococcal Conjugate | ________________________________ |

| **3rd visit – 2 months after 2nd visit:** | **Date (yy/mm/dd)** |
|---|---|
| Diphtheria | ________________________________ |
| Pertussis | ________________________________ |
| Tetanus | ________________________________ |
| Polio | ________________________________ |
| Haemophilus Influenzae Type b (Hib) | ________________________________ |
| Hepatitis B | ________________________________ |
| Pneumococcal Conjugate | ________________________________ |

| **4th visit – 12 months of age:** | **Date (yy/mm/dd)** |
|---|---|
| Measles | ________________________________ |
| Mumps | ________________________________ |
| Rubella | ________________________________ |
| Meningococcal C Conjugate | ________________________________ |
| Varicella (chicken pox) | ________________________________ |

| **5th visit – 12 months after 3rd visit:** | **Date (yy/mm/dd)** |
|---|---|
| Diphtheria | ________________________________ |
| Pertussis | ________________________________ |
| Tetanus | ________________________________ |
| Polio | ________________________________ |
| Haemophilus Influenzae Type b (Hib) | ________________________________ |
| Measles, Mumps, Rubella | ________________________________ |
| Pneumococcal Conjugate** | ________________________________ |

| **4 – 6 years of age:** | **Date (yy/mm/dd)** |
|---|---|
| Diphtheria | ________________________________ |
| Pertussis | ________________________________ |
| Tetanus | ________________________________ |
| Polio | ________________________________ |
| Varicella (chicken pox) | ________________________________ |
| **Other immunizations:** | |
| ________________________________ | ________________________________ |
| ________________________________ | ________________________________ |

***If your child has not been immunized, please initial here __________**

**Emergency Health Information:**

Care Card Number (**This info is a licensing requirement**): ___________________________________

Doctor: _________________________________ Phone: ________________________________

**Information to readily identify your child in case of an emergency:**

Hair colour: ___________________________ Eye colour: ______________________________

Height: ________________________________ Weight: _________________________________

Birthmarks: _______________________________________________________________________

Other identifying features: ________________________________________________________

**Emergency Consent**

It is the policy of Angel Care 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 call an ambulance to take the child to the nearest hospital. Please sign below so that we can take appropriate action on behalf of your child.

I hereby give my consent for my child, ________________________, when ill, to be taken to the nearest hospital by ambulance when I cannot be contacted.

| ____________________________ | _____________________________ | ______________________ |
|---|---|---|
| Signature of Parent/Guardian | Name (Please Print) | Date |

**Please note that a $30.00 registration fee must accompany this registration form. Registration forms will be accepted once all required information is completed.**

**Office use only**

Date Application Received: _______________________________________________

$30.00 Registration fee paid: ☐ Cash ☐ Cheque ☐ Debit/Credit ☐ Etransfer

Date Withdrawn: ___________________________