ANGEL CARE

Queen of Angels

Out of School Care Program

Kindergarten – Grade 6 Students

Licence # 1381622

2024 - 2025

Please attach a recent photo of your child.

Angel Care Out of School Program (OSC)

Kindergarten – Grade 6

2024-2025 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

$293.00 per month

(Includes early dismissal days)

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 received by our 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

Our Program is offered on a full-time basis, September – June. Pick-up by 5:30pm.

Start Date: _____

_____

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 <u>not permitted</u> to pick-up under any circumstances?

*If this is a parent with limited or restricted guardianship, <u>Court Documents</u> 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: _____