School District #35 (Langley) Student Registration

Office Use - MyEdBC	
YOG:	Grade:
School Year:	
Date:	

STUDENT INFORMATION

☐ Please ✓ box if student attended StrongStart ☐ Please ✓ box if Self-Identified Aboriginal Status (Complete Form)

Legal Last Name _____ Legal First Name _____ Legal Middle Name _____

Usual Last Name (if different) _____ Usual First Name (if different) _____ Usual Middle Name (if different) _____

Date of Birth (dd/mm/yyyy): _____ Birthplace (Country/Province): _____

Primary Language (Spoken at Home): _____ Gender: _____ Gender Identity: _____

Last School Attended (Name/City/Prov): _____ Langley Catchment School: _____

Street Address (Street/City/Postal): _____

Mailing Address (if different): _____

Who does the student reside with? ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Custody Order(s) **(Provide Copy)**

☐ Please ✓ box if **Child In-Care** (temporary or permanent) **Please provide a copy of Agreement/Court Order.**

PARENT INFORMATION (If student is "In-Care" Temporary or Permanent – Social Worker is #1/Care Provider is #2)

#1 Parent/Legal Guardian

First Name: _____ Last Name: _____ Relationship to Child: _____

Email: _____ Phone: _____ Work Phone: _____

Address (if different from student): _____

#2 Parent/Legal Guardian (If student is "In-Care" Care Provider is #2)

First Name: _____ Last Name: _____ Relationship to Child: _____

Email: _____ Phone: _____ Work Phone: _____

Address (if different from student): _____

EMERGENCY CONTACT INFORMATION (Other than Parent/Legal Guardian)

Emergency Contact #1: First/Last Name	Phone Number	Relationship to Child
Emergency Contact #2: First/Last Name	Phone Number	Relationship to Child
Emergency Contact #3: First/Last Name	Phone Number	Relationship to Child

HEALTH INFORMATION Is the condition(s) Life Threatening? ☐ Yes ☐ No **If yes**, Medical Form is required.

☐ Please ✓ box if child has a diagnosis: (i.e., Autism, Down Syndrome, Type 1 Diabetes, etc.) – Provide Assessments and reports.

☐ Please ✓ box if child has a current Individual Education Plan (IEP). Provide copy

Comments:

Care Card Number: _____ Vaccinated: ☐ Yes ☐ No Admin. Procedure 312

SIBLING INFORMATION (Brother/Sister) Name/Date of Birth (DOB – dd/mm/yyyy)

1. Name/DOB: _____ 2. Name/DOB: _____

3. Name/DOB: _____ 4. Name/DOB: _____

I understand as Parent/Legal Guardian, SD35 (Langley) will request the full student record (file), including all inclusions (if applicable), from last school attended.

PARENT/LEGAL GUARDIAN – SIGNATURE: _____ **DATE:** _____

"The information on this form is collected under the authority of the School Act, Section 13 and 79. The information provided will be used for educational program and administrative purposes, and when required, may be provided to health services, social services, or support services as outlined in Section 79(2) of the School Act. The information collected on this form will be protected consistent with the Freedom of Information and Protection of Privacy Act. If you have any questions about the information recorded on this form, please contact your School Administrator."

SCHOOL DISTRICT #45 (Langley)

MEDICAL ALERT FORM

Medical Alert Form		SCHOOL YEAR:
Last Name:		Photo ID (Parents do not send photo unless requested)
First Name:		
Division:		
Grade:		
Birth Date:		
Care Card #		

Contact Name & Telephone Numbers

Mother/Guardian Last Name:			Father/Guardian Last Name:		
Mother/Guardian First Name:			Father/Guardian First Name:		
Home Phone#		Mother/Guardian's Work or Cell		Father/Guardian's Work or Cell	
Physician Name			Telephone Number		

Indicate what medical condition this student has that may require emergency care at school:

Describe the potential problem (include symptoms that might be observed):

Describe the necessary action or intervention to appropriately treat this medical condition:	
Step 1	
Step 2	
Step 3	
Step 4	
Step 5	

Is medication needed? ◯ Yes ◯ No

If yes, what medication?

Prescribing Physician:

Parents must complete a **Request for Administration of Medication Form** if their child needs medication administered at school.

NOTE: No medication will be administered until this section of the medical form is completed. Parents need to ensure that this medication does not expire. It is the obligation of parents to keep a sufficient supply of any required medication at the school.

I have read and verified that the above information is correct.
By typing your name in the boxes below, you are digitally signing this form.

Parent/Guardian Last Name	Parent/Guardian First Name	Date

Copies to: ____Parent(s) ____Student G4 File ____Medical Alert Red Binder _____With medication

____Nursing Support Care Plan (if necessary) ____TOC Sub book _____Child's Fanny Pack

SCHOOL DISTRICT NO. 35 (LANGLEY)

REQUEST FOR ADMINISTRATION OF MEDICATION

NOTE: No medication will be administered until this form is completed and returned to the school.

A. This section is to be completed by a parent or legal guardian.

Student's Name: _____ School: _____

Birth date: _____ Grade: ____ Address: _____

Parent or Legal Guardian: _____

Phone - Home: _____ Bus.: _____ Cell: _____

Emergency contact: _____ Phone: _____

Family Physician: _____ Phone: _____

Prescribing Physician: _____ Phone: _____

B. Medication Required

Name of Medication	Dosage	Directions for Use	Medical Condition
1)			
2)			
3)			

C. I request that staff administer medication as prescribed on this form to my child:

_____
(Student's Name)

- I agree to supply the medication to the school in the **original container** with my child's name and the pharmacist's direction for use, including dosage.
- If changes occur I will contact the school and provide revised written instructions from a physician or pharmacist. I am aware I am required to update this information each September or sooner if required.
- I am aware that the Public Health Nurse for the school will be informed of my child's condition and medication and that the nurse may contact me as necessary.
- I am aware that staff working with my child may need to know of my child's condition and of the medication required
- I hereby give permission for my child's medical condition and required medication to be shared with relevant staff as required. Upon request, the Principal will provide the names of staff members that have been informed of my child's condition.

_____ _____
Date Signature of Parent or Legal Guardian

ABORIGINAL PROGRAM
Langley School District #35
4875-222nd Street, Langley, B.C. V3A 3Z7

Self-Identification of Aboriginal Ancestry
(First Nations, Metis or Inuit)

****Please fill out only if student has Aboriginal ancestry - one form per child****

Aboriginal Ancestry is determined on a voluntary basis through self-identification. This includes First Nations (Status or Non-Status), Metis or Inuit Ancestry. ***No documentation other than this self-identification is required and the ancestry can go back several generations.***

Student Name: _____Aboriginal Ancestry: ___Yes

Specify Ancestry if known:_____ (e.g. Sto:lo, Cree, Inuit, Metis, etc.)

School Attending: _____ Grade: _____

Student Birth Date:_____(month/day/year) Male: _____Female:_____

Home Phone #:_____ Cell #:_____ Email:_____

Siblings: _____ Grade:_____ School: _____
(with ancestry)

_____ _____ _____

*By signing below I acknowledge that my son/daughter is of Aboriginal Ancestry (First Nations, Metis or Inuit)

Parent/Guardian Consultation and Consent to Service

Aboriginal Education Programs/Services

- Academic and Personal Support
- Home-School communication (letters, phone calls, etc.)
- Monitoring of academic progress and attendance
- Cultural enrichment
- Graduation/Scholarship/Bursary/Post-Secondary Info
- Early Literacy/Numeracy Intervention
- PALS Program
- Newsletter
- In-class Cultural Presentations/Events
- Leadership Conference/Transition Conference

Comments: _____

*I give consent for my child to access the programs and services available through the Aboriginal Program. *This signature is considered consent for the duration of the student's enrollment in their current school. *Consent can also be given verbally by phone or by email to your Aboriginal Support Worker. *To revoke this consent you must contact the Aboriginal Program office at 604-888-4819.

*I give permission for my son/daughter's picture to be used in newsletters, webpage, etc. ___**Yes**____**No**

_____ _____
(Parent/Guardian Signature) **(Date Signed)**

_____ _____
(Print Parent/Guardian Name) **(Address - if changed)**

***Please return this form to your child's school ASAP. If you have any questions, please call 604-888-4819.**