



SEVEN OAKS SCHOOL DIVISION  
community begins here

# STUDENT REGISTRATION FORM

## Punjabi Bilingual Program

Class: \_\_\_\_\_ Teacher: \_\_\_\_\_

KINDERGARTEN ONLY: AM  PM  firm  flexible

This personal information is being collected under the authority of the Public Schools Act and will be used for educational purposes. It is protected by the Protection of Privacy provisions of The Freedom of Information and Protection of Privacy Act. If you have any questions about the collection, contact the Superintendent of Seven Oaks School Division, 830 Powers Street, Winnipeg, Manitoba, R2V 4E7; Telephone (204)586-8061.

Please Print

7Oaks Student #: \_\_\_\_\_

School: \_\_\_\_\_ Program: \_\_\_\_\_ School Year: \_\_\_\_\_ MET#: \_\_\_\_\_

LEGAL Surname: \_\_\_\_\_ LEGAL First Name: \_\_\_\_\_ LEGAL Middle Name: \_\_\_\_\_

Male  Female  Gender (if applicable) \_\_\_\_\_ Grade Level: \_\_\_\_\_ Birthdate: (Month/Day/Year) \_\_\_\_\_ Telephone: \_\_\_\_\_

Home Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_ Box #, Group #, RR#: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Transfer from: (School, City, Province, Country) \_\_\_\_\_

Do you live in the Seven Oaks School Division? Yes  No  (If NO, complete and attach a School of Choice / Out of Division Form)

Are you a Band sponsored First Nations student? Yes  If YES, name of Sponsor \_\_\_\_\_

If not a Canadian citizen are you: Landed Immigrant  Refugee  Visa Student  Date Entered Canada: (Month/Day/Year) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

To which ethnic / cultural group do you belong? \_\_\_\_\_ Language spoken at home: \_\_\_\_\_

Permanent Resident Number \_\_\_\_\_

**Guardians: (List in order of priority to call.)** Type of phone: c – cell h – home w – work (List in order of priority to call.)

1. LAST Name \_\_\_\_\_ FIRST Name \_\_\_\_\_ Relation \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ e-mail address: \_\_\_\_\_

Legal Guardian? Yes  No  Phone 1: \_\_\_\_\_ type: \_\_\_\_\_ Phone 2: \_\_\_\_\_ type: \_\_\_\_\_ Phone 3: \_\_\_\_\_ type: \_\_\_\_\_

2. LAST Name \_\_\_\_\_ FIRST Name \_\_\_\_\_ Relation \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ e-mail address: \_\_\_\_\_

Legal Guardian? Yes  No  Phone 1: \_\_\_\_\_ type: \_\_\_\_\_ Phone 2: \_\_\_\_\_ type: \_\_\_\_\_ Phone 3: \_\_\_\_\_ type: \_\_\_\_\_

3. LAST Name \_\_\_\_\_ FIRST Name \_\_\_\_\_ Relation \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_ e-mail address: \_\_\_\_\_

Legal Guardian? Yes  No  Phone 1: \_\_\_\_\_ type: \_\_\_\_\_ Phone 2: \_\_\_\_\_ type: \_\_\_\_\_ Phone 3: \_\_\_\_\_ type: \_\_\_\_\_

**CUSTODY:** Are there any legal restrictions/arrangements for this child? Yes  No

(A copy of legal documents must be on file at school.)

**Emergency Contact (EC) - Must be different than Guardians 1, 2 and 3** Type of phone: c – cell h – home w – work

EC 1 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone 1: \_\_\_\_\_ type: \_\_\_\_\_ Telephone 2: \_\_\_\_\_ type: \_\_\_\_\_

EC 2 Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone 1: \_\_\_\_\_ type: \_\_\_\_\_ Telephone 2: \_\_\_\_\_ type: \_\_\_\_\_

Doctor: \_\_\_\_\_ MB Medical: Personal #: (9 digit) 

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 Family #: (6 digit) 

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Doctor Phone Number: \_\_\_\_\_

**Attending / Registered at Daycare/After School Care**

Name: \_\_\_\_\_ Contact: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ or \_\_\_\_\_

**Signature:** (Verifying that the above information is true and correct.)

PARENT/GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

<b>SIBLINGS</b>	Name: _____ Birthdate: _____ Grade: _____ School: _____
	Name: _____ Birthdate: _____ Grade: _____ School: _____
	Name: _____ Birthdate: _____ Grade: _____ School: _____

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## MEDICAL QUESTIONNAIRE

Please complete the following. Specify yes, if physician diagnosed.

1. Life Threatening Allergy YES  NO  If yes, specify: \_\_\_\_\_
2. Prescribed an EpiPen YES  NO
3. Asthma YES  NO
4. Bleeding Disorder YES  NO
5. Diabetes YES  NO
6. Heart Condition YES  NO
7. Seizure Disorder YES  NO
8. Other **significant** conditions that are physician diagnosed (i.e. ulcerative colitis, Crohns, transplants, spina bifida, permanent physical limitations)  
\_\_\_\_\_  
\_\_\_\_\_

This medical information is being collected so that appropriate health care plans may be developed. This information will only be shared with appropriate individuals. This information is protected by the Personal Health Information Act. Questions should be directed to the Superintendent of Seven Oaks School Division, 830 Powers Street, Winnipeg, Manitoba, R2V 4E7; Telephone (204)586-8061

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## SUPPORT SERVICES

Please indicate if student has utilized any of the following services:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Psychiatry        | <input type="checkbox"/> Reading Recovery Teacher    | <input type="checkbox"/> School Counsellor |
| <input type="checkbox"/> Psychology        | <input type="checkbox"/> Resource Teacher            | <input type="checkbox"/> Physiotherapy     |
| <input type="checkbox"/> Social Work       | <input type="checkbox"/> Occupational Therapy        | <input type="checkbox"/> Outside Agency    |
| <input type="checkbox"/> Speech & Language | <input type="checkbox"/> <b>Child in Care of CFS</b> | <input type="checkbox"/> Other             |

If any services above are (✓), please complete details below.

Name of Agency/Support Service: \_\_\_\_\_

Name of Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Briefly describe the reason for service: \_\_\_\_\_

The Support Services information is being collected so that appropriate educational services may be provided for your son/daughter. This information will only be shared with appropriate individuals. This information is protected by the Freedom of Information and Protection of Privacy Act. Questions should be directed to the school principal.

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## INDIGENOUS IDENTITY DECLARATION

*The Aboriginal Identity Declaration helps to support the efforts of Manitoba Education and Training and school divisions to plan and improve programs in a way that is responsive to Aboriginal Learners. **Providing this personal information is voluntary and optional.** It is being collected in compliance with section 36(1)(b) of the Freedom of Information and Protection of Privacy Act (FIPPA) as it is necessary for and relates directly to the activity of Manitoba and school divisions to plan, deliver and improve programs.*

I, \_\_\_\_\_, (name of parent / guardian, please print clearly):

- Am submitting my child's Aboriginal Identity Declaration for the first time;  
 Am making changes to my child's Aboriginal Identity Declaration;  
 I have already submitted my child's Aboriginal Identity Declaration and have no changes

Is your child an Aboriginal person, that is, First Nation (North American Indian), Métis, or Inuk (Inuit)? Note: First Nations (North American Indian) include Status & Non-Status Indians. If "Yes", mark the square(s) that best describe(s) your child now:

- Yes, First Nation (North American Indian)  
 Yes, Métis  
 Yes, Inuk (Inuit)

Which best describes your child's Aboriginal cultural-linguistic identify? Please select up to two choices:

- Anishinaabe (Ojibway/Saulteaux)  
 Ininew (Cree)  
 Dene (Sayisi)  
 Dakota  
 Oji-Cree  
 Michif  
 Inuktitut  
 Other \_\_\_\_\_