

For Office Use Only

Information Verified by (Staff Name): _____

**Staff
Initial**

CATCHMENT SCHOOL: _____ **Date:** _____

- Current Year** – Enrollment Date: _____ Grade: _____
- Next Year:** Date of Registration: _____ Time of Registration: _____ Current/Next Grade: _____
- Cross Boundary:** Yes No **If Yes, Name of Cross Boundary School Requested:** _____

REGISTRATION DOCUMENTATION:

Proof of Age:

- Birth Certificate
- Certificate of citizenship
- Immigration Canada documents
- Passport
- Permanent Resident Card
- Indigenous Status Card
- Driver's License (if over 19)

Proof of Residency:

- Driver's License
- Rental Agreement
- Municipal Tax Bill
- Utility Bill
- Parent's Care Card
- Parent's BC Services Card

Proof of Physical Address (catchment area schools only):

- Driver's License
- Proof of Purchase of Residence
- Municipal Tax Bill
- Notary Authorized Letter
- Rental Agreement, accompanied with:
 - Hydro, Gas, Cable or Telephone Bill
 - Mortgage Statement

STUDENT INFORMATION:

Legal Last Name: _____ Usual Last Name: _____
 Legal First Name: _____ Usual First Name: _____
 Legal Middle Name: _____ Usual Middle Name: _____
 Birth Date: _____ Age: _____ Legal Gender: M F / Preferred: M F Transgender
(DD-MM-YYYY) (If Applicable)
 Home Phone No. _____ Cell Phone No. _____
 Student Email (if applicable): _____
 Address: _____
Apt #, Street Name City Province/Postal Code

Mailing Address *if different from above:* _____

CITIZENSHIP: Country of Birth: _____ Citizen of: _____ Immigration Status: _____

LANGUAGE: At Home _____ Most Used _____ First _____

INDIGENOUS ANCESTRY: NO / If YES, please tick the applicable ancestry below:

- Inuit
- Metis
- Non-Status
- Status-Off Reserve
- Status-On Reserve

Band of Origin: _____ Band of Residence: _____

PREVIOUS SCHOOL: _____ **District #:** _____ **City:** _____

Has student ever attended a **Mission school or StrongStart Program** YES NO Name of School: _____

MEDICAL: Care Card Number: _____ Doctor's Name: _____ Phone: _____

Student has potentially life threatening condition. Details: _____

Please arrange a meeting with the school Principal if the student has a medically diagnosed life-threatening condition.

To be filled out by Principal or designate when a life threatening medical condition exists: Doctor's Note Requested
 Doctor's Note Received

SPECIAL NEEDS or LEARNING CONSIDERATIONS:

Identified Learning Needs / Special Needs: Yes No **Specify:** _____

Student currently has an **Individualized Education Plan (IEP):** Yes No If yes, current designation(s): _____

Other information: _____

PARENTS(GUARDIANS) & CONTACTS

Parent/Guardian #1: Relationship: _____

Last Name: _____

First Name: _____

Home Ph: _____ Cell Ph: _____

Work Ph: _____ Email: _____

Living with Student: Yes No Has Custody: Yes No

Can pick up?: Yes No Speaks English: : Yes No

Address if different: _____

CUSTODY Are there any legal documents in force re:

Custody/Guardianship/Access Yes No

If yes, have you provided the school with a copy of these legal documents? Yes No

Parent/Guardian #2: Relationship: _____

Last Name: _____

First Name: _____

Home Ph: _____ Cell Ph: _____

Work Ph: _____ Email: _____

Living with Student: Yes No Has Custody: Yes No

Can pick up?: Yes No Speaks English: : Yes No

Address if different: _____

CUSTODY – if Agency Representative (eg. MCFD):

Continuing Custody Order Temporary Custody Order

If yes, have you provided the school with a copy of these legal documents? Yes No

EMERGENCY CONTACT INFORMATION:

Contact #3: Relationship: _____

Last Name: _____

First Name: _____

Home Ph: _____ Cell Ph: _____

Work Ph: _____ Email: _____

Can pick up?: Yes No Speaks English: : Yes No

Contact #5: Relationship: _____

Last Name: _____

First Name: _____

Home Ph: _____ Cell Ph: _____

Work Ph: _____ Email: _____

Can pick up?: Yes No Speaks English: : Yes No

(Other than Parents / Guardians)

Contact #4: Relationship: _____

Last Name: _____

First Name: _____

Home Ph: _____ Cell Ph: _____

Work Ph: _____ Email: _____

Can pick up?: Yes No Speaks English: : Yes No

Contact #6: OUT OF DISTRICT CONTACT

Relationship: _____

Last Name: _____

First Name: _____

Home Ph: _____ Cell Ph: _____

Work Ph: _____ Email: _____

SIBLING INFORMATION

Sibling #1 Relationship: _____

Name: _____

DOB: _____ Age: ____ Grade: ____ Gender: ____

School: _____

Sibling #3 Relationship: _____

Name: _____

DOB: _____ Age: ____ Grade: ____ Gender: ____

School: _____

Sibling #2 Relationship: _____

Name: _____

DOB: _____ Age: ____ Grade: ____ Gender: ____

School: _____

Sibling #4 Relationship: _____

Name: _____

DOB: _____ Age: ____ Grade: ____ Gender: ____

School: _____

Other Notes or Comments:

I verify that the information contained in this registration is accurate and complete.

Parent/Guardian Name (*Please print*): _____

Parent/Guardian Signature (if student is under 19): _____ Date _____

The information on this form is collected under the authority of the School Act, Sections 13 & 79; and may be used by the District for Ministry of Education reporting; demographic, enrolment, budget facility and operational analysis. It will be kept secure and confidential in accordance with the Freedom of Information and Protection of Privacy Act.