



Application for Admission

I hereby make application for admission to the Cedar Valley Waldorf School:

Program Requested:

Commencement Date: _____

Parent & Child – Friday 9:30 – 11:30

Preschool (child must be toilet trained)- Please indicate preferred times.

Mon.& Tues. 9:00 a.m. to 12:00 p.m.

Wed. & Thurs 9:00 a.m. to 12:00 p.m.

Preschool aftercare (child must be no longer napping)Wed. & Thurs 12:00 p.m. to 3:00 p.m

I would be willing to enroll in a different session if my first choice is not available.

Kindergarten

Half Day

5 days a week (Mon. – Fri. 9:00 a.m. to 12:00 p.m.)

3 days a week (Mon - Wed. 9:00 a.m. to 12:00 p.m.)

Full Day

5 days a week (Mon. – Thurs. 9:00 a.m. to 3:00 p.m., Fri. 9:00 a.m. to 12:00 p.m.)

3 days a week (Mon - Wed. 9:00 a.m. to 3:00 p.m.)

Grade _____ (insert grade child is entering) (Mon. – Thurs. 8:45 a.m. to 3:15 p.m., Fri. 8:45 a.m. to 12:00 p.m)

Friday aftercare: (available noon to 5:00 p.m.) Please indicate pick up time: _____

I would be interested in expanded aftercare for 2012/13 school year.

Student's Legal Name: _____
Surname First Name Middle Name(s)

Date of Birth: _____ Female Male

A copy of your child's birth certificate needs to be attached for this application to be considered complete.

Birthplace _____ Citizenship _____
(if not Canada, we require proof of status – see attached legal residency form)

Current School Name: _____

Address: _____

Phone #: _____

**Parental Information:**

Name of **Mother** _____

Address - Physical & Mailing _____

City _____

Province _____ Postal Code _____

Home Phone _____ E-Mail _____

Business Phone _____ Cell Phone _____

Occupation _____ Company _____

Name of **Father** _____

Address - Physical & Mailing _____

City _____

Province _____ Postal Code _____

Home Phone _____ E-Mail _____

Business Phone _____ Cell Phone _____

Occupation _____ Company _____

Name of **Legal Custodial Guardian/Agent** _____

Address - Physical & Mailing _____

City _____

Province _____ Postal Code _____

Home Phone _____ E-Mail _____

Business Phone _____ Cell Phone _____

Occupation _____ Company _____

Sibling Information:

Names: _____ School(s): _____

Grades: _____ Dates of Birth: _____ Also Applying? Male Female



Other Information:

Mother: Interests/Hobbies/Talents: _____

Father: Interests/Hobbies/Talents: _____

Guardian/Agent: Interests/Hobbies/Talents _____

If either, or both parents are deceased, if parents are separated or divorced, please state so and give name and relationship to the pupil of all adults and/or children living in the household:

Household where your child resides during the week: Mother & Father Mother Father Guardian
 Other _____

Language(s) spoken in the home: _____

Doctor's Name _____ Phone: _____

Child's Medical Plan Health Number or Insurance Policy Details:

Please provide us with alternate emergency contacts and people you authorize to pick up your child in case we are unable to contact you.

Authorized Pick Up/Emergency Contact _____ Phone _____

Authorized Pick Up/Emergency Contact _____ Phone _____

Authorized Pick Up/Emergency Contact _____ Phone _____

In case of snow or other extraordinary circumstances in which transportation and/or communication may be interrupted, we need to know where or with whom your child should go:

Early dismissal Contact Person _____ Phone: _____

Do you authorize the Cedar Valley School to take care of your child during an emergency if we are unable to contact you? This may include transportation to the hospital and basic first aid.

Yes No

Parent/Guardian Signature(s)

_____ Date: _____



MEDICAL INFORMATION

Does your child have any medical conditions? Please describe together with any treatments.

Please state any known allergies (food/animal/medication) and symptoms experienced. _____

Does your child have any physical challenges? _____

Does your child have any special fears? _____

Give a brief evaluation of your child's health: _____

What are your child's basic sleep patterns? _____

How is your child's diet (concerns?): _____

Has your child recently had a hearing test? Yes No

Been diagnosed with a hearing problem? Yes No

History of chronic ear infections? Yes No

Has your child recently had a test for vision? Yes No

Known vision problems? Yes No

Does your child wear glasses or contacts? Yes No

Comments: _____



Please check the appropriate boxes if your answer is 'yes' to any of the following questions

Has your child had any of the following illnesses?
Or ever been immunized for any of the following illnesses?

Chicken Pox	<input type="checkbox"/> ILLNESS	<input type="checkbox"/> IMMUNIZED (YR./MTH.) _____
Measles (Rubeola)	<input type="checkbox"/> ILLNESS	<input type="checkbox"/> IMMUNIZED (YR./MTH.) _____
German Measles (Rubella)	<input type="checkbox"/> ILLNESS	<input type="checkbox"/> IMMUNIZED (YR./MTH.) _____
Mumps	<input type="checkbox"/> ILLNESS	<input type="checkbox"/> IMMUNIZED (yr/mth) _____
Whooping Cough(Pertussis)	<input type="checkbox"/> ILLNESS	<input type="checkbox"/> IMMUNIZED (yr/mth) _____
Poliomyelitis	<input type="checkbox"/> ILLNESS	<input type="checkbox"/> IMMUNIZED (YR./MTH.) _____
Diphtheria	<input type="checkbox"/> ILLNESS	<input type="checkbox"/> IMMUNIZED (YR./MTH.) _____
Tetanus	<input type="checkbox"/> ILLNESS	<input type="checkbox"/> IMMUNIZED (YR./MTH.) _____
Haemophilus B	<input type="checkbox"/> ILLNESS	<input type="checkbox"/> IMMUNIZED (YR./MTH.) _____
Hepatitis B	<input type="checkbox"/> ILLNESS	<input type="checkbox"/> IMMUNIZED (YR./MTH.) _____

Is your child receiving...

Medication?	Yes	No
Medical Attention?	Yes	No
Psychological help?	Yes	No

Does your child suffer from...

Hyperactivity?	Yes	No
Dyslexia?	Yes	No
Other learning disability?	Yes	No

Has your child had any of the following illnesses or conditions?

- Asthma
- Hay Fever
- Scarlet Fever
- Diabetes
- Epilepsy
- Convulsions/Fits

Has your child ever experienced any of the following?

- Concussion
- Major Surgery
- Admission to Hospital

At birth was your child....

Premature?	Yes	No
Very small?	Yes	No
Given special care?	Yes	No



Has your child ever exhibited behaviours (i.e. aggression, use of inappropriate language etc.) that were a particular challenge for you or any other care provider/teacher? If so, please describe the behaviour and include what steps were taken _____

Do you have any further comments or concerns that would help us in our work with your child? (Include professional or therapeutic support) _____

Parent/Guardian Signature(s)

Mother: _____
Year Month Day

Father: _____
Year Month Day

Guardian: _____
Year Month Day

IMPORTANT: Your application can only be processed if ALL the information on these pages is completed.

Application Checklist: Please include these with documents with your application.

- Photo of child (preschool applications only)
- Copy of the child's immunization records (preschool applications only)
- Copy of the child's birth certificate
- Completed forms attached: Student Emergency Info, School Walks Consent Form, Personal Information Privacy Consent Form, Homeopathic Consent Form, Legal Residency Form

A one-time non-refundable fee must accompany this application:
 \$55.00 Attached

For office: Use Only	Received _____	\$55 App. Fee _____
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