



**VALOUR COMMUNITY CENTRE**  
**SCHOOL REC PROGRAM REGISTRATION FORM 2020 - 2021**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_ Current Age \_\_\_\_\_

Postal Code \_\_\_\_\_ Gender  Male  Female Birth Date \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Room # \_\_\_\_\_ Teacher \_\_\_\_\_

Parent \_\_\_\_\_ Occupation \_\_\_\_\_ Work # \_\_\_\_\_

Address (if different) \_\_\_\_\_ Home # \_\_\_\_\_

E-mail \_\_\_\_\_ Cell # \_\_\_\_\_

Parent \_\_\_\_\_ Occupation \_\_\_\_\_ Work # \_\_\_\_\_

Address (if different) \_\_\_\_\_ Home # \_\_\_\_\_

E-mail \_\_\_\_\_ Cell # \_\_\_\_\_

Emergency contact(s) \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Child(s) pick up list \_\_\_\_\_

**MEDICAL INFORMATION**

Family Doctor \_\_\_\_\_ Phone # \_\_\_\_\_

Manitoba Health # \_\_\_\_\_ Child's 9 Digit Health # \_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

Please indicate any medical conditions, limitations, allergies, required medications, etc.

\_\_\_\_\_

\_\_\_\_\_

**CONSENT**

I, the undersigned, being the parent/guardian of \_\_\_\_\_ do hereby give permission for her/him to travel and participate in activities associated with Valour Community Centre School Rec Program. I also acknowledge all risks and hazards incidental to such participation including transportation to and from activities. I give permission to any Doctor or Dentist to render emergency treatment as such Doctor or Dentist deems necessary, subject to the following restrictions:

Start Date \_\_\_\_\_ Please check all applicables:  Before School

*If taking a bus:*  After School

Pick up time \_\_\_\_\_ Drop off time \_\_\_\_\_  Lunch

Location \_\_\_\_\_  Half Days

Perferred drop off/pick up times \_\_\_\_\_  Full Days

Can we e-mail you newsletters, flyers, announcements, etc?  Yes  No

Parent or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_