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Sucker Creek First Nation

P.O. Box 65 Builda, AB  
T0G 0W0

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**K3/K4 Aboriginal Head Start Program**  
**Child Registration Form**

**Identification of the Child**

Full Legal Name: \_\_\_\_\_

Nick Name: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Alberta Health Care Number: \_\_\_\_\_

Treaty Number: \_\_\_\_\_ Band Name: \_\_\_\_\_

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

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

Preferred Language: English \_\_\_\_\_ Cree: \_\_\_\_\_

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**Identification of the Parent(s)/Guardian(s)**

Mother's Legal Name: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Place of Employment: \_\_\_\_\_

Father's Legal Name: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Place of Employment: \_\_\_\_\_

Emergency Contact Person(s) #1: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Place of Employment: \_\_\_\_\_

Directions on how to get to residence in case of emergency (Please include legal land description and house number):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency Contact Person(s) #2: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Place of Employment: \_\_\_\_\_

Directions on how to get to residence in case of emergency (Please include legal land description and house number):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Child's Medical Information**

Family Physician Name: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_

Is your child up to date on immunization? Yes \_\_\_ No \_\_\_

Is your child immunized through the Sucker Creek Health Center? Yes \_\_\_ No \_\_\_

If no, where is your child immunized through? \_\_\_\_\_

Does your child have any allergies? Yes \_\_\_ No \_\_\_

If yes, what types of allergies? \_\_\_\_\_

\_\_\_\_\_  
What are the reaction symptoms? \_\_\_\_\_  
\_\_\_\_\_

How long until the reaction starts? \_\_\_\_\_  
\_\_\_\_\_

Is there medication to be administered? Yes \_\_\_ No \_\_\_

If yes, what kind of medication and how is the administered? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of medication: \_\_\_\_\_

Amount to be administered: \_\_\_\_\_

Other important information regarding medication? \_\_\_\_\_  
\_\_\_\_\_

Medical/Health Problems? Yes \_\_\_ No \_\_\_

Please briefly explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there medication to be administered? Yes \_\_\_ No \_\_\_

If yes, what kind of medication and how is it administered? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of medication: \_\_\_\_\_

Amount to be administered: \_\_\_\_\_

Other important information regarding medication? \_\_\_\_\_  
\_\_\_\_\_

**Information about your child**

What are your child's favorite foods? \_\_\_\_\_  
\_\_\_\_\_

What are your child's least favorite foods? \_\_\_\_\_  
\_\_\_\_\_

How does your child react in public places? \_\_\_\_\_  
\_\_\_\_\_

Does your child play well with others? \_\_\_\_\_

When your child gets upset, how does he/she react? \_\_\_\_\_

Does your child have any issues with hitting/biting? \_\_\_\_\_

Is your child in a napping routine? Yes \_\_\_\_ No \_\_\_\_

If yes, what is the regular time and how long do they usually nap for? \_\_\_\_\_

Is your child right \_\_\_\_ or left \_\_\_\_ handed?

Does your child have any fears that we should be aware of? Yes \_\_\_\_ No \_\_\_\_

What are the fears? \_\_\_\_\_

How is your child usually calmed down? \_\_\_\_\_

Does your child require assistance when using the bathroom? Yes \_\_\_\_ No \_\_\_\_

Washing hands \_\_\_\_\_ Undressing/dressing \_\_\_\_\_ Wiping \_\_\_\_\_ Brushing teeth \_\_\_\_\_

What are specific indications that your child needs to use the bathroom? \_\_\_\_\_

How are your child's eating habits? Please explain: \_\_\_\_\_

Do you have any concerns regarding your child's behavior that we should be aware of? Example:

Extreme shyness, insecurity, separation anxiety? \_\_\_\_\_

Do you have any concerns regarding your child's development that we should be aware of?

Example: using scissors, tying shoes, and growth? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are there any physical limitations that we need to be aware of? Example: speech or hearing?

\_\_\_\_\_

\_\_\_\_\_

Has your child even been tested by a professional? Example: speech pathologist, psychologist, or hearing? \_\_\_\_\_

\_\_\_\_\_

What are some of your child's special gifts? \_\_\_\_\_

\_\_\_\_\_

What are your child's favorite activities? \_\_\_\_\_

\_\_\_\_\_

Does your child require transportation? Yes \_\_\_ No \_\_\_

If yes, is the transportation required both to and from home or are there other arrangements?

\_\_\_\_\_

\_\_\_\_\_

If going to a babysitter please provide information of name, phone number, and location:

\_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Sucker Creek First Nation**

**K3/K4 Aboriginal Head Start Program**

**Consent Form**

**Medical Treatment**

I \_\_\_\_\_, give consent for the staff of the Sucker Creek First Nation K3/K4 Aboriginal Head Start Program to seek medical attention for my child in the event of an emergency. I would prefer my child to be seen by (physician) \_\_\_\_\_, if possible.

\_\_\_\_\_  
Parent/ Guardian Signature

\_\_\_\_\_  
Date

**Photo/Name**

I \_\_\_\_\_, give consent for my child to be photographed, videotaped, and have his/her name displayed only by the Sucker Creek First Nation K3/K4 Aboriginal Head Start Program for the purpose of promotion and/or display of the program.

\_\_\_\_\_  
Parent/ Guardian Signature

\_\_\_\_\_  
Date

**Transportation**

I \_\_\_\_\_, give consent for my child to be transported by the staff of the Sucker Creek First Nation K3/K4 Aboriginal Head Start Program only in the bus for the purpose of day-to-day programming, including field trips. (There will be field trip notification for each field trip).

\_\_\_\_\_  
Parent/ Guardian Signature

\_\_\_\_\_  
Date



Sucker Creek First Nation

K3/K4 Aboriginal Head Start Program

Parental Consent

I/We \_\_\_\_\_ will commit to participating in the Sucker Creek First Nation K3/K4 Aboriginal Head Start Program as parent(s) or guardian(s) of the child \_\_\_\_\_, who will be accessing the program. The commitment that is required is to attend a parent session and a family event monthly. In the sessions there will be programming, and activities based on program and parental needs. **This commitment is mandatory for the program, and will be an incentive to the success of the program.**

\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_  
Parent/Guardian Signature Date

I/We \_\_\_\_\_, have read and understand the Policies and Procedures Handbook from the K3/K4 Aboriginal Head Start Program.

\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_  
Parent/Guardian Signature Date



**Sucker Creek First Nation**

**K3/K4 Aboriginal Head Start Program**

**Release Form**

I, \_\_\_\_\_ give permission to the following person/persons to pick up my child at the center on the days when I am unable to.

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

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

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

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

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

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

Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date

**Please note: The Sucker Creek First Nation K3/K4 Aboriginal Head Start Staff must be informed ahead of time when any of these people will be picking up your child or meeting the bus.**