



# CHRISTIAN HERITAGE SCHOOL

2025 26<sup>th</sup> Street, Brandon, Manitoba, R7B 3Y2

Phone (204) 725-3209, Fax (204) 728-9641

Email office@chsbrandon.ca, www.chsbrandon.ca

## 2022-2023 Student Registration Form

(One form per student - please include a copy of student's birth certificate)

### Student Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Common name called: \_\_\_\_\_ Gender  Male  Female

Birth Date (dd/mm/yyyy): \_\_\_\_\_ Present Age: \_\_\_\_\_ Desired Start Date: \_\_\_\_\_

Entering Grade: \_\_\_\_\_ If Kindergarten, indicate Mornings only or Full Day: \_\_\_\_\_

Birthplace: \_\_\_\_\_ Language(s) spoken at home: \_\_\_\_\_

Citizenship Status:  Canadian Citizen Date of entry if not born in Canada (dd/mm/yyyy): \_\_\_\_\_

Visitor Record Expiry Date (dd/mm/yyyy): \_\_\_\_\_

Permanent Resident Date of Entry (dd/mm/yyyy): \_\_\_\_\_

Refugee Date of Entry (dd/mm/yyyy): \_\_\_\_\_

Student lives with:  Father & Mother  Father  Mother  Other: \_\_\_\_\_

Mother: \_\_\_\_\_ Cell: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Father: \_\_\_\_\_ Cell: \_\_\_\_\_ E-Mail: \_\_\_\_\_

### School History

(for students entering Grades 1-8 only)

Name of current or most recent school: \_\_\_\_\_

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

City: \_\_\_\_\_ Province: \_\_\_\_\_ Country: \_\_\_\_\_

School Division: \_\_\_\_\_ School Phone: \_\_\_\_\_

Teacher's Name: \_\_\_\_\_ Principal's Name: \_\_\_\_\_

Last Grade Completed: \_\_\_\_\_ \*MET Number: \_\_\_\_\_

*\*A MET number is your child's Manitoba Education Tracking number. It likely can be found on his or her report card, or from the administrative office of the school your child attends. If you are new to Manitoba, please leave this blank.*

Has the student ever:

- Been suspended     Repeated any grade
- Been refused admission to, or dismissed/expelled from, another school

Comments:

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

- |                                                    |                                                                      |
|----------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Resource Assistance       | <input type="checkbox"/> Physiotherapy                               |
| <input type="checkbox"/> Reading Recovery Support  | <input type="checkbox"/> Psychological                               |
| <input type="checkbox"/> Speech & Language         | <input type="checkbox"/> Professional Clinical Diagnosis<br>(attach) |
| <input type="checkbox"/> Behavioural Support / BIP | <input type="checkbox"/> Professional Counselling                    |
| <input type="checkbox"/> Level 2 or 3 Funding      | <input type="checkbox"/> Outside Agency                              |
| <input type="checkbox"/> Gifted / Enrichment       | <input type="checkbox"/> Other:                                      |
| <input type="checkbox"/> Social work               | _____                                                                |
| <input type="checkbox"/> Occupational Therapy      | _____                                                                |

**If any services above are checked, please complete the info below. Provide more info if necessary.**

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

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

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

Briefly describe the reason for service:

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

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

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

Briefly describe the reason for service:

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## Medical Information

**The parent(s) / guardian(s) are responsible to provide the school office with any updated medical information as soon as possible.**

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

Student's 9-digit MB Medical Number: \_ \_ \_ \_ \_

Family 6-digit MB Medical Number: \_ \_ \_ \_ \_

Does the student have a Unified Referral & Intake System (URIS) form on file with another school or Public Health?  Yes  No

Please state any medical conditions that CHS should be aware of:

(Check Yes or No. If Yes, add comment and supporting documentation or information)

Allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
EpiPen	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
Vision Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
Hearing Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
Other <b>significant</b> conditions that are physician diagnosed (i.e. ulcerative colitis, Crohns, transplants, spina bifida, permanent physical limitations, mental illness, etc.):		

*In the event that I cannot be reached at the time of an accident, I hereby authorize the staff of Christian Heritage School to call an ambulance to provide first aid and transportation to Brandon Regional Hospital for treatment for my child.*

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Emergency Contact

Please list two people (other than parent(s) / guardian(s)) who can take immediate action in the event the school personnel are unable to contact parent(s) / guardian(s) in the event of an emergency.

Name:	Phone Number(s):	Relationship to Student:	Available Daytime:	Lives with Student:	Aware of this responsibility:
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Aboriginal Identity Declaration

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 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 for the first time
- Am making changes to my child's Aboriginal Identity Declaration
- Already submitted my child's Aboriginal Identity Declaration and have no further changes to make at this time

Is your child an Aboriginal person, that is, First Nation (North American Indian), Métis or Inuk (Inuit)?

**Note:** First Nations (North American Indian) includes Status and 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 identity? Please select up to two choices:

- Anishinaabe (Ojibway/Saulteaux)
- Ininiw
- Dene (Sayisi)
- Dakota
- Oji-Cree
- Michif
- Inuktitut
- Other – please specify: \_\_\_\_\_