

**Webber Academy Junior Kindergarten Programme**  
**Student Information Form**

(To be completed, returned, and kept in classroom as per *Alberta Children's Services* regulation.)

**Section One: Personal Information**

Child's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

**Parents/Legal Guardian Information**

Mother's Name: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Address: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

Employee's Address: \_\_\_\_\_

Business Telephone Number: \_\_\_\_\_ Cellular Number: \_\_\_\_\_

Mother's e-mail address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Address: \_\_\_\_\_ Home Telephone: \_\_\_\_\_

Employee's Address: \_\_\_\_\_

Business Telephone Number: \_\_\_\_\_ Cellular Number: \_\_\_\_\_

Father's e-mail address: \_\_\_\_\_

**Section Two: Medical/Health Information**

Alberta Health Care Number: \_\_\_\_\_ (\*Note: if child has private health insurance, please provide copy.)

Please list any allergies that the child has: \_\_\_\_\_

Weight \_\_\_\_\_ Height \_\_\_\_\_ Number of Siblings \_\_\_\_\_

Was the child healthy at birth? Yes/No

Hospitalization (Date and Diagnosis, if applicable) \_\_\_\_\_

Childhood Illnesses – Please complete below, if applicable

| Date of Illness          | Yr | Mo | Day |                      | Yr | Mo | Day |
|--------------------------|----|----|-----|----------------------|----|----|-----|
| Measles                  |    |    |     | Head Injury          |    |    |     |
| Rubella (German Measles) |    |    |     | Accidental Poisoning |    |    |     |
| Chicken Pox              |    |    |     | Fracture             |    |    |     |
| Mumps                    |    |    |     | Ear Infection        |    |    |     |
| Convulsions              |    |    |     | Bronchitis           |    |    |     |
| Whooping Cough           |    |    |     | Other                |    |    |     |
|                          |    |    |     |                      |    |    |     |

Does child hear well? Yes/No

See well? Yes/No

Has the child had his hearing checked? Yes/No

Vision examined? Yes/No



General Health \_\_\_\_\_

Has this child any medical or emotional condition requiring treatment or supervision? \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

Please list any ongoing medications that the child receives (i.e. epi-pens): \_\_\_\_\_

(\*Please attach a photocopy of the child's immunization record. Thank you.)

**Section Three: Emergency Contact Information**

Please list the information for two individuals who may be contacted in case of emergency.

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

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

Telephone Numbers: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

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

Telephone Numbers: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

Please list the names of any individuals who are authorized to take the child from the school.

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

