SUM-SHA-THUT-LELLUM

PREK PROGRAM

2025/2026 REGISTRATION

PLEASE NOTE:

All CHILDREN REGISTERING MUST TURN 3 by December 31, 2025

- Registration begins March 3, 2025 at 8:30am for **T'SOU-KE NATION**
- Registration begins March 14, 2025 at 8:30am for **STATUS FIRST NATIONS CHILDREN** (children must have their own Status or Métis Card) **AND CURRENTLY REGISTERED CHILDREN**.
- Registration begins April 2, 2025 at 8:30am for **GENERAL PUBLIC** .

All registrations are to be dropped off at the T'Sou-ke Administration office. Staff must date and sign all registration forms as they come in. Spots are given on a First -Come - First Serve-basis

All Registration Forms must be COMPLETELY filled out and include items listed below or WILL NOT BE ACCEPTED.

Please ensure your child's form includes:

- Start Date
- Childs Personal Heath Number
- Please attach 2 photos of child
- Copy of child's immunization records

PREK PROGRAM START DATE: September 2, 2025

DUE AT TIME OF REGISTRATION: All registrant's **accepted** into PreK program are require to pay a deposit of $300 due at time of registration. (Members Exempt)

ALL DEPOSITS ARE NON-REFUNDABLE

Sum-SHA-thut-Lellum's Registration Form
(Include a photo of child)

CHILD'S STARTING DATE: / / **SEX**: M___ F___ **DATE OF BIRTH:** / /

NAME OF CHILD: _____
(Surname) (Given Names) (Also known as)
Name the child responds to:_____
Address:_____
Postal Code:_____Phone:_____
Person(s) with whom the child lives (adults and children):_____
Child's first language:_____ Other Languages:_____

T'SOU-KE NATION MEMBER ☐ **STATUS ABORIGINAL** ☐ **NON-ABORIGINAL** ☐

PARENT(S) / GUARDIAN(S):
Name:_____ Home Phone:_____ Cell Phone:_____
Work Phone:_____ Days/hours of work:_____ E-mail:_____
Name:_____ Home Phone:_____ Cell Phone:_____
Work Phone:_____ Days/hours of work:_____ E-mail:_____

MEDICAL INFORMATION
Child's Doctor_____ Phone:_____
Child's Dentist_____ Phone:_____
Child's Personal Health Number:_____

ALTERNATE PERSON TO CALL/PICK-UP CHILD IN CASE OF EMERGENCY:
Name:_____ Relationship to Child:_____
Home Phone: _____Work Phone:_____ CellPhone:_____
Name:_____ Relationship to Child:_____
Home Phone: _____Work Phone:_____ Cell Phone:_____

PERSONS (OTHER THAN PARENT/GUARDIAN AND EMERGENCY CONTACTS) **AUTHORIZED TO PICK UP CHILD FROM FACILITY:**
Name:_____ Relationship to Child:_____
Home Phone: _____Work Phone:_____ Cell Phone:_____
Name:_____ Relationship to Child:_____
Home Phone: _____Work Phone:_____ Cell Phone:_____
Name:_____ Relationship to Child:_____
Home Phone: _____Work Phone:_____ Cell Phone:_____

PERSONS NOT PERMITTED TO ACCESS TO CHILD:
Name:_____ Phone:_____
Name:_____ Phone:_____
Are there Custody orders? YES ☐ NO ☐ If answered yes please provide a copy to facility.

HAS THE CHILD PREVIOUSLY ATTENDED DAYCARE/PRESCHOOL?
YES ☐ NO ☐ Comments:_____

COMMENTS/INSTRUCTIONS TO HELP US CARE FOR YOUR CHILD (PLEASE FEEL FREE TO ADD ADDITIONAL PAGES)
Toileting (special words):_____
Rest Time (special comfort-toy/blanket):_____
Eating/Mealtime (include food likes/dislikes):_____
Fears:_____

PLEASE TELL US ANYTHING ELSE YOU THINK WILL HELP US PROVIDE AN ENRICHING EXPERIENCE FOR YOUR CHILD:

_____

_____

DOES YOUR CHILD HAVE:

A medical condition/concern? YES ☐ NO ☐ If yes, please provide further information:_____

Allergies? YES ☐ NO ☐ If yes, please provide further information:_____

Asthma? YES ☐ NO ☐ If yes, please provide further information:_____

Has your child had a seizure in the past year? YES ☐ NO ☐ If yes, please provide further information:_____

Does your child require a special diet related to a medical condition? YES ☐ NO ☐ If yes, please provide further information:_____

Food sensitivities? YES ☐ NO ☐ If yes, please provide further information:_____

BASIC SCHEDULE AND RECORD OF IMMUNIZATIONS AS SUBMITTED BY PARENT/GUARDIAN
(ATTACH IMMUNIZATION RECORD - OR RECORD THE DATES)

	1ST VISIT @ 2 MO.	2ND VISIT 2 MO. AFTER 1ST	3RD VISIT 2 MO. AFTER 2ND	4TH VISIT 12 MO. OF AGE	5TH VISIT 12 MO. AFTER 3RD	5-6 YRS.	GRADE 6	GRADE 9
INDICATE DATES IMMUNIZATION RECEIVED								
DIPHTHERIA	*	*	*		*	*		*
PERTUSSIS	*	*	*		*	*		
TETANUS	*	*	*		*	*		*
POLIOMYELITIS	*	*	*		*	*		
HIB1	*	*	*		*			
MEASLES				*	*			
MUMPS				*	*			
RUBELLA				*				
HEPATITIS B	*2	*2	*2				*3	

BY MY SIGNATURE BELOW I ACKNOWLEDGE THE FOLLOWING:

I HEREBY GIVE MY CONSENT FOR A STAFF MEMBER TO CALL A MEDICAL PRACTITIONER OR AMBULANCE FOR MY CHILD IN THE CASE OF ILLNESS, IF I CANNOT IMMEDIATELY BE REACHED.

PARENT'S SIGNATURE: **DATE:** / /

THIS BOX FOR OFFICE USE ONLY

DATE RECEIVED _____ **SIGNATURE** _____