

# P.O.O.S.C.A.

(PARKDALE OUT OF SCHOOL CARE ASSOCIATION 1991)

THE NEXT BEST PLACE TO HOME

North Glenmore Park Community Assoc.

2231 Longridge Dr., SW.

Tel: 403-714-1410 or 403-999-4616

E-Mail: [pooscacgs@gmail.com](mailto:pooscacgs@gmail.com)

PERSONAL AND CONFIDENTIAL  
(Please complete all areas)

START DATE:      /      /       
                  D      M      Y

NAME: \_\_\_\_\_

DATE OF BIRTH:      /      /      SCHOOL \_\_\_\_\_ GRADE: \_\_\_\_\_  
                  D      M      Y

CHILD'S ADDRESS: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_ (Cell) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TELEPHONE: (H) \_\_\_\_\_ (B) \_\_\_\_\_

E-MAIL: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ (Cell) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TELEPHONE: (H) \_\_\_\_\_ (B) \_\_\_\_\_

E-MAIL: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

DAYS ATTENDING: M T W TH F START DATE: \_\_\_\_\_

TIMES ATTENDING: BEFORE: \_\_\_\_\_ / AFTER: \_\_\_\_\_

FULL TIME: \_\_\_\_\_ PART TIME: \_\_\_\_\_

PROFESSIONAL DAYS: YES: \_\_\_\_\_ NO: \_\_\_\_\_

PLEASE SPECIFY CHILD CARE IF NOT FULL TIME: \_\_\_\_\_

CHILD WILL BE PICKED UP BY: \_\_\_\_\_

CHILD NOT TO BE RELEASED TO: \_\_\_\_\_

ALTERNATE EMERGENCY CONTACTS AVAILABLE DURING PROGRAM HOURS:

NAME: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

COMMENTS?: (ANYTHING AFFECTING THE CARE OF YOUR CHILD) \_\_\_\_\_

ALBERTA HEALTH CARE NUMBER: \_\_\_\_\_

MEDICAL INFORMATION (ALLERGIES, ONGOING MEDICATION, ETC): \_\_\_\_\_

ARE ALL IMMUNIZATION RECORDS CURRENT? \_\_\_\_\_ YES \_\_\_\_\_ NO

Cultural or Ethnic family background \_\_\_\_\_

This will be helpful when we are doing Multi-cultural activities throughout the year

I would be willing to share my culture (artifacts, recipes, language info, etc) yes \_\_\_\_\_ no \_\_\_\_\_

CONSENT FOR MEDICAL ATTENTION:

I \_\_\_\_\_ HEREBY AUTHORIZE EMERGENCY CARE FOR \_\_\_\_\_  
PARENT/GUARDIAN (PLEASE PRINT) CHILD'S NAME

\_\_\_\_\_  
PARENT'S SIGNATURE

\_\_\_\_\_  
TERMINATION DATE

P.O.O.S.C.A.

CHILD TRAVEL & EMERGENCY INFORMATION

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
MOM: \_\_\_\_\_ HOME: \_\_\_\_\_ BUS: \_\_\_\_\_ CELL: \_\_\_\_\_  
HOME ADDRESS: \_\_\_\_\_  
DAD : \_\_\_\_\_ HOME: \_\_\_\_\_ BUS: \_\_\_\_\_ CELL: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
AHC # : \_\_\_\_\_ ALLERGIES: \_\_\_\_\_  
ALL IMMUNIZATION RECORDS CURRENT: YES \_\_\_\_\_ NO \_\_\_\_\_  
ONGOING MEDICATION OR CURRENT MEDICAL INFO: \_\_\_\_\_  
EMERGENCY CONTACT: \_\_\_\_\_ PHONE# \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

EMERGENCY RESPONSE # - 911

POISON CONTROL CENTRE- # - 1-800-332-1414