Beautiful Plains School Division

REGISTRATION FORM

HAZEL M KELLINGTON SCHOOL

CURRENT GRADE LEVEL: _____

MALE_____ FEMALE_____ NOT DISCLOSED_____ NAME TO BE USED IN SCHOOL:_____

LEGAL NAME: _____
(LAST) (FIRST) (MIDDLE)

DATE OF BIRTH: _____ LANGUAGES SPOKEN AT HOME: _____
MONTH/DAY/YEAR

TOWN/COUNTRY OF BIRTH: _____ ENTRY DATE TO CANADA: _____
(IF APPLICABLE)

STREET/HOME ADDRESS _____ P.O. BOX _____
(HOUSE & STREET # OR SECTION TOWNSHIP RANGE (NE 5-15-17)

CITY/TOWN _____ POSTAL CODE _____ PHONE NUMBER _____

PARENT _____ CELL NUMBER _____ WORK PHONE _____

PARENT'S EMPLOYER _____ PARENT'S EMAIL ADDRESS_____

PARENT _____ CELL NUMBER _____ WORK PHONE_____

PARENT'S EMPLOYER _____ PARENT'S EMAIL ADDRESS_____

BABYSITTER (IF APPLICABLE) _____ HOME/CELL #_____

EMERGENCY CONTACT NAME (other than parents or guardians): _____

HOME/CELL#: _____

BROTHERS AND SISTERS (IN SCHOOL & PRESCHOOL)

NAME: DATE OF BIRTH: M/D/Y:	NAME: DATE OF BIRTH: M/D/Y:	NAME: DATE OF BIRTH: M/D/Y:
NAME: DATE OF BIRTH: M/D/Y:	NAME: DATE OF BIRTH: M/D/Y:	NAME: DATE OF BIRTH: M/D/Y:

A: STUDENT LIVES WITH: ___ BOTH PARENTS ___ FATHER ___ MOTHER ___ OTHER (PLEASE SPECIFY) _____
IF PARENTS ARE SEPARATED AND CHILD SPENDS TIME AT BOTH PARENTS' HOMES, PLEASE PROVIDE THE NAME AND ADDRESS OF THE PARENT NOT LISTED ABOVE. PARENT NAME_____
ADDRESS _____
LEGAL CUSTODY: ___ JOINT ___ FATHER ONLY ___ MOTHER ONLY ___ OTHER (PLEASE SPECIFY) _____
NOTE: ANY RESTRICTIONS OF CONTACT WITH CHILD: YES ____ NO____ (IF YES, PLEASE SUPPLY WITH COPY OF LEGAL DOCUMENT.)
DOCUMENT ON FILE: _____ YES _____NO

B: MEDICAL INFORMATION:
FAMILY MEDICAL #: (6 DIGIT) _____ PERSONAL HEALTH ID #: (9 DIGIT) _____
FAMILY DOCTOR: _____ TELEPHONE NUMBER: _____
SIGNIFICANT MEDICAL CONDITIONS: _____

C: BUS DRIVER (IF APPLICABLE): _____ BUS #: _____
NAME & ADDRESS OF BILLET IN THE EVENT OF A STORM THAT REQUIRES STUDENTS TO REMAIN IN TOWN.
NAME: _____ ADDRESS: _____ HOME/CELL #: _____

D: INFORMATION: STUDENTS TRANSFERRING IN:
NAME AND ADDRESS OF SCHOOL LAST ATTENDED: _____
_____

E:
PARENT SIGNATURE: _____ DATE: _____

PARENT SIGNATURE: _____ DATE: _____

Beautiful Plains School Division

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.)

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

NO _____ YES _____

If you have answered NO, please return this form to your child's school.
If you have answered YES, please complete the remainder of the form and return to your child's school.

I, _____, (name of parent/Guardian, please print clearly)

☐ Am submitting my child's Aboriginal Identity Declaration 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 First Nation (North American Indian), Metis or Inuk (Inuit)? Note: First Nations (North American Indian) include Status and Non-Status Indians
If "Yes", mark the square(s) that best describe(s) your child now:

☐ Yes, First Nation First Nation (North American Indian)
☐ Yes, Metis
☐ Yes, Inuk (Inuit)

Which best describes your child's Aboriginal cultural-linguistic identity? Please select up to two choices:

☐ Anishinaable (Ojibway/Saulteaux)
☐ Ininiw
☐ Dene (Sayisi)
☐ Dakota
☐ Oji-Cree
☐ Michif
☐ Inuktitut
☐ Other – please specify: _____

FOR OFFICE/SCHOOL USE ONLY:

BIRTH CERTIFICATE VERIFICATION:

DATE: _____

INITIALS: _____

	COPY OF CITIZENSHIP
	COPY OF PASSPORT
	COPY OF REPORT CARD/TRANSCRIPT
	COPY OF BIRTH CERTIFICATE

NEWCOMER/EAL:

	PERMANENT RESIDENT
	NON-RESIDENT (REG.VISA PUPIL)
	NON-RESIDENT (NON SUPPORTABLE)

	URIS FORM COMPLETED
	FEES MENTIONED (IF APPLICABLE)
	SCHOOL OF CHOICE PAPERWORK (IF APPLICABLE)

GRADE: **TEACHER:** **START DATE:**

Beautiful Plains SCHOOL DIVISION

Responsible Student Use of Technology Agreement

BPSD supports and encourages the use of technology to enhance and facilitate learning. Technology supports educational environments that are innovative, creative, and engaging. This agreement applies to student use of BPSD and personal technology. BPSD technology resources include computers, devices, email, internet and network services.

PART A RESPONSIBLE USE OF TECHNOLOGY

BPSD is committed to educating responsible digital citizens who RESPECT, EDUCATE, and PROTECT themselves and others. When using BPSD technology or personal devices, all students are required to:

- Take precautions to ensure personal privacy is protected (avoid sharing personal or identifying information online).
- Protect the privacy of others (do not share their personal information, images, or video without consent).
- Be respectful to all (do not use technology to degrade, defame, bully, or harass others).
- Avoid inappropriate or offensive online content (do not access, forward, or share).
- Abide by copyright laws and fair-use guidelines for electronic content.
- Do not post/download/share illegal software, music, movies, or content.
- Report any concerns, misuse, or abuse of technology to school personnel.
- Take full responsibility for, and respectfully use any technology provided.
- Use personal technology only when permission is granted, and keep it stored away when not in use.
- Turn off all peer-to-peer software when using personal technology at school (music, video, and file-sharing).
- Connect only to school approved Wi-Fi sources or networks.

PART B PARENT/GUARDIAN AGREEMENT

1. As the Parent/Legal Guardian of the student listed on this form, I fully understand, accept, and support the responsible use of technology as outlined in PART A, and will review this agreement with my child (when age-appropriate).

2. I understand that the security, connectivity, care, and maintenance of my child's personal technology is my responsibility, and that BPSD will not be responsible for the loss, theft, or damage as such. I also understand that when my child connects to the BPSD network, their personal technology may be monitored. I further acknowledge that the school principal or designate, at their discretion, may access and search my child's personal technology - if there are reasonable grounds to believe a breach of school rules or policies has occurred.

3. I acknowledge that this agreement allows for my child to be given access to the Internet for educational purposes. This includes the use of, but is not limited to, desktop/mobile applications, email(G-suite) accounts or other services. I also recognize that BPSD cannot filter or restrict access to all unacceptable materials on the Internet. [*BPSD is confident in the effectiveness of our Internet filtering services, be we also recognize that there are no perfect filters. School staff will do their utmost to ensure students arrive at appropriate websites. Students are educated regarding online safety and best practices of digital citizenship, and we encourage parents/guardians to engage in discussion with their children on such matters.]*

4. I understand and accept that BPSD will not assume legal liability for the inappropriate or illegal use of technology by my child, and I agree to report any unacceptable online behavior of my child to the school principal or designate. This includes, but is not limited to, communication or postings that indicate or suggest unethical or illegal activities, racism, hatred, or harassment. Furthermore, I recognize that violation of the terms of this agreement may result in loss of BPSD network use for my child, and/or possible disciplinary action.

STUDENT:_____ **SCHOOL:**_____ **DATE:** _____
DAY/MONTH/YEAR

PARENT/GUARDIAN:_____ _____
PRINT NAME *SIGNATURE REQUIRED*

This agreement shall remain in effect as long as your child is registered with the Beautiful Plains School Division, and is applicable for all grades. If you have any concerns or questions, please contact the school principal.
Updated: October 2019

Beautiful Plains
School Division

Media Release Form For Students

Beautiful Plains School Division (BPSD) acknowledges that a variety of different types of public relations initiatives exist to promote our students.

These include:

1. Internal
    - School updates of print and online material that is circulated within the division
2. External
    - School updates of print material to inform our community
    - Requests by media for interviews, photographs and/or video footage of school and/or divisional events
    - Content on our divisional/school website and divisional/school-based social media.

Please complete the following permission form to give your child permission to be included in the above information. To give permission, please check "Yes" in the boxes below.

Please Note:

- All signed release forms are valid until otherwise specified in writing to your child's school
- Parental cancellation of permission applies to materials/media produced for any upcoming internal/external public releases (ex. School/classroom newsletters, etc.)

Name of Student:_____
(Please print)

Name of School: _____

As the parent/legal guardian, by checking ***"No"*** to any of the boxes below, I understand that I **DO NOT GIVE** permission to reproduce, exhibit, broadcast and distribute through printed, audio, visual or electronic means, my child's photograph, video image, work samples or quotations for the following purposes:

☐ Yes ☐ No School/Divisional content of print and online material

☐ Yes ☐ No Requests by media for interviews, photographs and/or video footage of school and/or divisional events

Name of Parent or Legal Guardian:_____
(Please print)

Date:_____ Signature of Parent or Legal Guardian:_____

PRAIRIE MOUNTAIN HEALTH

Community Program Representative ☐

UNIFIED REFERRAL AND INTAKE SYSTEM (URIS) GROUP B APPLICATION (a)

Review application, complete and sign in ink

The purpose of this form is to identify the child's specific health care and if applicable, apply for URIS Group B support which includes the development of a health care plan and training of community program staff by a registered nurse. URIS is a partnership of Health, Education and Family Services. If you have questions about the information requested on this form, you may contact the community program.

Section I – To be completed by the community program

Type of community program *(please √)*	Community Program Name: Hazel M Kellington School	Location of Service: ☑ Same as on left
☑ School ☐ Licensed child care ☐ Respite ☐ Recreation program ☐ Other: _____	Contact person: Allen Hanke	Contact person:
	Phone: 204-476-2323 Fax:	Phone: Fax:
	Email: ahanke@bpsd.mb.ca	Email:
	Mailing address: Box 696 Street address: Neepawa, MB City/Town: R0J 1H0 Postal Code:	Mailing address: Street address: City/Town: Postal Code:

Section II - Child information - to be completed by parent

Last Name | **First Name** | **Birthdate** (Y Y Y Y M M M D D)

Preferred Name (Alias) | **Age** | **Grade** | **Gender** ☐ M ☐ F ☐ Other

Does your child ride the bus? ☐ YES ☐ NO

Does your child have any of the following listed health concerns? ☐ YES ☐ NO **(check (√) one)**

➢ If you have answered **NO**, please sign here and return this form to the community program.

Parent/ Legal Guardian NAME | *Parent/Legal Guardian SIGNATURE* | *DATE (YYYY/MMM/DD)*

➢ If you have answered **YES**, please complete the remainder of the form **including Section III**.

➢ Please check (√) all health care conditions for which the child requires an intervention during attendance at the community program. Return the completed form to the community program.

☐ YES ☐ NO	**Life-threatening allergy and child is prescribed an injector (e.g. Epi-Pen®/ Taro Epinephrine®/ Allerject®)** ☐ YES ☐ NO Does the child bring an injector to the community program?
☐ YES ☐ NO	**Asthma (administration of medication by inhalation)** ☐ YES ☐ NO Does the child bring reliever medication (puffer) to the community program? ☐ YES ☐ NO Does your child know **when** to take their reliever medication (puffer) e.g. can recognize signs of asthma? ☐ YES ☐ NO Can your child take their reliever medication (puffer) **on their own**? IF NO, describe what your child needs help with:_____
☐ YES ☐ NO	**Seizure disorder What type of seizure(s) does the child have?** _____ ☐ YES ☐ NO Does the child require administration of rescue medication? ☐**Lorazepam** ☐**Midazolam** ☐ YES ☐ NO Does the child require the use of a vagal nerve stimulator (wand)?
☐ YES ☐ NO	**Diabetes What type of diabetes does the child have?** ☐ **Type 1** ☐ **Type 2** ☐ YES ☐ NO Does the child require blood glucose monitoring at the community program? ☐ YES ☐ NO Does the child require assistance with blood glucose monitoring? ☐ YES ☐ NO Does the child have low blood glucose emergencies that require a response?

☐ YES ☐ NO	**Ostomy Care** ☐ YES ☐ NO Does the child have an ostomy/stoma? ☐ YES ☐ NO Does the child require the ostomy pouch to be emptied at the community program? ☐ YES ☐ NO Does the child require the established appliance to be changed at the community program? ☐ YES ☐ NO Does the child require assistance with ostomy care at the community program?
☐ YES ☐ NO	**Gastrostomy Care** ☐ YES ☐ NO Does the child have a gastrostomy tube? Type of tube: _____ ☐ YES ☐ NO Does the child require gastrostomy tube feeding at the community program? ☐ YES ☐ NO Does the child require administration of medication via the gastrostomy tube at the program?
☐ YES ☐ NO	**Clean Intermittent Catheterization (CIC)** ☐ YES ☐ NO Does the child require CIC? ☐ YES ☐ NO Does the child require assistance with CIC at the community program?
☐ YES ☐ NO	**Pre-set Oxygen** ☐ YES ☐ NO Does the child require pre-set oxygen at the community program? ☐ YES ☐ NO Does the child bring oxygen equipment to the community program?
☐ YES ☐ NO	**Suctioning (oral and/or nasal)** ☐ YES ☐ NO Does the child require oral and/or nasal suctioning at the community program? ☐ YES ☐ NO Does the child bring suctioning equipment to the community program?
☐ YES ☐ NO	**Cardiac Condition where the child requires a specialized emergency response at the community program.** What type of cardiac condition has the child been diagnosed with? _____
☐ YES ☐ NO	**Bleeding Disorder (e.g., von Willebrand disease, hemophilia)** What type of bleeding disorder has the child been diagnosed with? _____
☐ YES ☐ NO	**Endocrine Conditions (e.g. steroid dependence, congenital adrenal hyperplasia, hypopituitarism, Addison's disease)** What type of steroid dependence has the child been diagnosed with? _____
☐ YES ☐ NO	**Osteogenesis Imperfecta (brittle bone disease)** What type? _____

Section III - Authorization for the Release of Medical Information

In accordance with *The Personal Health Information Act* (PHIA),I authorize the Community Program, the Unified Referral and Intake System Provincial Office, and the nursing provider serving the community program, all of whom may be providing services and/or supports to my child, to exchange and release medical information specific to the health care interventions identified above and consult with my child's health care provider, if necessary, for the purpose of developing and implementing an Individual Health Care Plan/Emergency Response Plan and training community program staff for

Child's Name: _____ ***Child's PHIN:*** _____

I also authorize the Unified Referral and Intake System Provincial Office to include my child's information in a provincial database which will only be used for the purposes of program planning, service coordination and service delivery. This database may be updated to reflect changing needs and services. I understand that my child's personal and personal health information will be kept confidential and protected in accordance with *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA).

I understand that any other collection, use or disclosure of personal information or personal health information about my child will not be permitted without my consent, unless authorized under FIPPA or PHIA.

Consent will be reviewed with me annually. I understand that as the parent/legal guardian I may amend or revoke this consent at any time with a written request to the community program.

If I have any questions about the use of the information provided on this form, I may contact the community program directly.

_____ _____ _____

NAME (PRINT) Parent/ Legal Guardian *SIGNATURE Parent/Legal Guardian* *DATE (YYYY/MMM/DD)*

Mailing Address: _____ City/Town: _____ Postal Code: _____

Work/Daytime Phone: _____ Cell Phone: _____ Home Phone: _____

Email: _____