

Bait-ul-Ilm - Academic Year 2016-2017

STUDENT REGISTRATION FORM

Note: All required fields have an asterisk (*). Illegible, missing or incorrect information will lead to a delay in the registration

First Name*		Middle Name		Last Name*	
Date of Birth* (mm/dd/yyyy)		Country of Birth		Gender* O Female O Male	
Address*				Country*	
State/Province*		City*		Zip/Postal Code*	
Student's Home Phone*		Student's Cell Phone		Student's Email Address	
Father's Name* (First, M, Last)		Father's Cell Phone		Father's Email Address	
Mother's Name* (First, M, Last)		Mother's Cell Phone		Mother's Email Address	
Emergency/Guardian Name*		Relationship	Phone Number*	Email Address	
Secular School Name*				School Grade* (as of September 2010)	
School System:		O Public O Private O Other			
Date of Immigration to Canada if applicable (mm/yyyy)		Jamatkhana Attending		Year Joined BUI in Canada	Primary Language Spoken at Home
Which of these Early Childhood Development (ECD) programs has your child participated in? (Check all that apply)					
O PIAR O LCPC O Other (external) formal Pre-Kindergarten ECD Program (e.g. Montessori)					
Medical Information (allergies, medications, special needs etc.)				PHOTO	
_____ has a potentially life threatening allergy (anaphylaxis): <i>(Name of the Student - first and last name)</i>				<i>(please provide the picture of the child - Legally required for the schools)</i>	
Allergies:	<input type="checkbox"/> Peanuts	<input type="checkbox"/> Eggs	<input type="checkbox"/> Insect stings	<input type="checkbox"/> Medications	
	<input type="checkbox"/> Tree Nuts	<input type="checkbox"/> Milk	<input type="checkbox"/> Latex	<input type="checkbox"/> Other:	
Medical Dosage:	Epipen Jr 0.15 mg	Epipen 0.30 mg	Twinjet 0.15 mg	Twinjet 0.30 mg	

Special Needs/Symptoms of the Anaphylactic reactions (please select from the following):

Skin: Hives, swelling, itching, redness, rash

Respiratory (breathing): Wheezing, shortness of breath, throat tightness, cough, hoarse voice, chest pain/tightness, nasal congestion or hay fever-like symptoms (runny itchy nose and watery eyes, sneezing), trouble swallowing.

Gastrointestinal (stomach): Nausea, pain/cramps, vomiting, diarrhea

Cardiovascular (hear): Pale/blue colour, weak pulse, passing out, dizzy/lightheaded, shock

Other: Anxiety, feeling of "impending doom", headache

Any other symptoms (please specify): _____

The undersigned patient, parent or guardian authorizes any adult to administer epinephrine to the above-named person in the event of an anaphylactic reaction, as described above. This protocol has been recommended by the patient's physician.

Parent/Guardian Signature/Consent _____ **Date:** _____

Additional Comments

CONSENT:

The personal information contained in this form is being collected by ITREB Canada for the purpose of providing and administering religious education and for the purpose of providing ITREB Canada and the Council of Canada with demographic and aggregate statistical data and for use in developing and communicating short-term and long-term initiatives for the Canadian Jamat. By providing the personal information above I, _____, on behalf of my son/daughter, consent to the collection, use and disclosure of the personal information for the purposes stated above. I understand that this consent may be withdrawn by providing notice in writing to ITREB Canada at 4010 Canada Way, Burnaby, British Columbia, V5G 1G8.

I hereby consent to having my child's audio, video and photographs (Recordings) taken at Baitul-Ilm. I understand that ITREB Canada will only use these Recordings for curriculum, training and promotion of related materials, and that there will be no compensation paid for the use of these Recordings.

Parent/Guardian Signature: _____ Date: _____

For Office Use Only

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