



# SCHOOL DISTRICT NO. 46 (Sunshine Coast)

STUDENT REGISTRATION FORM School: \_\_\_\_\_

PLEASE PRINT CLEARLY

GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	LEGAL Family Name	LEGAL First Name	LEGAL Middle Name	No Legal Middle Name <input type="checkbox"/>
USUAL Family Name(s) (if different)		PREFERRED First Name (if different)	PREFERRED Middle Name (if different)	
Birth Date ____ - ____ - ____ dd mmm yyyy		Age	<b>For Office Use Only</b> <b>PROOF OF LEGAL NAME &amp; AGE</b> Staff Initials _____	
Home Phone ( )	Unlisted <input type="checkbox"/> Yes <input type="checkbox"/> No	Entering Grade _____	<input type="checkbox"/> BC Identification <input type="checkbox"/> Court Order <input type="checkbox"/> Vital Statistics Documents	<input type="checkbox"/> Birth Certificate <input type="checkbox"/> Driver's Licence <input type="checkbox"/> Passport
Home Address Street No. Street Name		Apt. No.	City	Prov <b>BC</b> Postal Code
<b>For Office Use Only</b> <b>PROOF OF ADDRESS</b> <input type="checkbox"/> Credit Card Invoice <input type="checkbox"/> Driver's Licence <input type="checkbox"/> Mortgage Statement <input type="checkbox"/> Municipal Tax Bill <input type="checkbox"/> Rental Agreement <input type="checkbox"/> Utility Bill				
Mailing Address if different from Home Address Street No. Street Name Apt. No. City Prov Postal Code				
Ever attended a BC School <input type="checkbox"/> Yes <input type="checkbox"/> No	Previous District	Previous School or StrongStart Centre	Previous School Prov	Previous School Country
Previous School Phone (if known) ( )		Previous School Fax No. (if known) ( )		
Name of sibling(s) at this school _____				
BIRTHPLACE Country of Birth: _____ Prov. of Birth: _____		<b>For Office Use Only - CITIZENSHIP</b> <input type="checkbox"/> Canadian Citizen <input type="checkbox"/> Out of Prov Cdn - Funding Not Eligible <input type="checkbox"/> International Funding Eligible <input type="checkbox"/> Permanent Res / Landed Immigrant <input type="checkbox"/> International Funding Not Eligible		Language spoken at home: Eng. <input type="checkbox"/> Fr <input type="checkbox"/> Other (specify): _____
<b>PLEASE INDICATE IF THE STUDENT HAS ABORIGINAL ANCESTRY</b> <input type="checkbox"/> Aboriginal <input type="checkbox"/> First Nations Status <input type="checkbox"/> First Nations Non-Status <input type="checkbox"/> Metis <input type="checkbox"/> Inuit				

<b>CUSTODY</b> <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother Only <input type="checkbox"/> Father Only <input type="checkbox"/> Guardian <input type="checkbox"/> Joint Custody <input type="checkbox"/> COURT ORDER (copy in student file) <input type="checkbox"/> Other (specify) _____			<b>LIVES WITH</b> <input type="checkbox"/> Both Parents <input type="checkbox"/> Mother Only <input type="checkbox"/> Father Only <input type="checkbox"/> Guardian <input type="checkbox"/> Joint Custody <input type="checkbox"/> Other (specify) _____		
<input type="checkbox"/> MOTHER or <input type="checkbox"/> STEPMOTHER or <input type="checkbox"/> LEGAL GUARDIAN			<input type="checkbox"/> FATHER or <input type="checkbox"/> STEPFATHER or <input type="checkbox"/> LEGAL GUARDIAN		
Last Name		First Name	Last Name		First Name
Address (if not living with student)			Address (if not living with student)		
Willing to Volunteer <input type="checkbox"/> Yes <input type="checkbox"/> No			Willing to Volunteer <input type="checkbox"/> Yes <input type="checkbox"/> No		
Work Phone ( )	Ext / Local	Available at Work <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone ( )	Ext / Local	Available at Work <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Phone ( )	Unlisted <input type="checkbox"/> Yes <input type="checkbox"/> No		Home Phone ( )	Unlisted <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cell Phone ( )	Pager		Cell Phone ( )	Pager	
Email Address			Email Address		

Family Doctor's Name	Doctor's Phone ( )	STUDENT'S CARE CARD NO
<b>HEALTH FACTORS</b> Check if applicable <input type="checkbox"/> Anaphylactic <input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Other Additional Information: _____		Are any of these conditions <b>LIFE THREATENING?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify: _____
<b>Other Health Conditions</b> which may require emergency care – please specify. _____		
<input type="checkbox"/> The student requires medication to be administered during school hours for <b>one month or longer</b> . Please contact school staff to discuss and to plan. Name of Medication(s) _____		

