John N.A. Janvier School
REGISTRATION FORM
GRADE 7 - 9

IMPORTANT: Please submit a copy of your child's birth certificate if you have not done so in previous school years

JOHN N.A. JANVIER SCHOOL

BOX 1680, COLD LAKE, AB T9M 1P4
PHONE (780) 594-3733 FAX (780) 594-5845

Registration Form * School Year: _____

** A COPY OF THE STUDENT BIRTH CERTIFICATE IS REQUIRED FOR ALL STUDENTS **

STUDENT INFORMATION **ENTERING GRADE:** ☐

Student Legal Name: _____
(on birth certificate) LAST FIRST MIDDLE

Student Preferred Name (if different from above)

_____
LAST FIRST MIDDLE

Birthdate: _____ / _____ / _____
YY MM DD

Health Care Number: _____

Treaty Number: _____ Band Name: _____
(full 10 digit number please)

PARENT / GUARDIAN INFORMATION

Student lives with: _____PARENTS _____ FATHER ONLY _____MOTHER ONLY _____ GUARDIAN
(collected to enable communication to an appropriate address)

Parent/Guardian Names:

Parent/Guardian Mailing Address:

Physical Address (off reserve/on reserve) #

Parent/Guardian email address:

Parent/Guardian Phone number: *(M) mother/(F) father/(G) Guardian* (as relevant)

Home (M): _____ Work (M): _____ Cell (M): _____

Home (F): _____ Work (F): _____ Cell (F): _____

Home (G): _____ Work (G): _____ Cell (G): _____

EDUCATION INFORMATION

Name of last school attended:

Phone number:

Does your child have an Individual Program Plan (IPP)? (please circle) Yes OR No

EMERGENCY CONTACT INFORMATION

In case of an emergency, school closure, or if we are unable to contact parents/guardians, please provide us with the full names and phone numbers of emergency contact people:

NAME:	RELATIONSHIP:	PHONE:
NAME:	RELATIONSHIP:	PHONE:

MEDICAL INFORMATION

Are there any medical concerns your child may be experiencing that the school should be aware of? (physical disabilities/allergies/serious illness)

Please explain:

CUSTODY

A child may be designated as "protected", if a court has issued a restraining order under the Child Welfare Act, the Domestic Relations Act, the Divorce Act, or the Young Offenders Act. Please indicate if the school administration should be aware of any such court order for the protection of your child.

YES or NO

If yes, please arrange to discuss this situation with the school administration. Legal documentation will be required for student's personnel file.

I hereby declare that I have read and understood the information contained on this form, and the information I have provided is correct.

Parent/Guardian Signature: _____

Date: _____

RELEASE FORM FOR STUDENT NAME AND IMAGES

John N.A. Janvier School is proud of our students and their accomplishments. We take every opportunity to showcase their talents.

This consent form is to be completed under the following circumstances:

- When the media or an outside organization takes photos and/or records videos or when interviews are undertaken where individual students are identified by name:

OR

- When the school takes photos and/or records videos where individual students can be identified and the material is to be used for the purposes inside or outside the school.

I, _____ hereby consent for _____
(Name of Parent/Guardian) (Name of Student)

For my child to be interviewed, photographed, or videotaped during the course of my child's

SIGNED THIS _____ DAY OF _____, 20_____.

_____
Parent/Guardian Signature

SCHOOL RELIGION & MASS PERMISSION

There will be a celebration of four masses throughout the school year:

- Beginning of the Year/Thanksgiving
- Christmas
- Ash Wednesday
- Year-End

To ensure we respect your requests, please complete this form and return it to the school with your completed registration package.

Student Name: _____

RELIGION CLASSES

_____ I wish my child to participate in religion classes for the school year

_____ I do not wish my child to participate in religion classes for the school year

MASSES

_____ I wish my child to participate in the mass celebrations for the school year

_____ I would like my child to serve mass with the priest as an alter girl/boy (Gr 4-8)

_____ I would like my child to have the opportunity to read scriptures during mass

_____ I would like my child to have the opportunity to participate in the offertory

_____ I would like my child to have the opportunity to participate in the choir for all masses

_____ I DO NOT my child to participate in the mass celebrations for the school year

_____ _____

Parent Signature Date

HEALTH AND WELLNESS EDUCATION

Throughout the school year as a part of the health and wellness curriculum, students will be participating in activities related to human sexuality. Topics covered are approved according to Alberta's Health and Wellness curriculum and include but are not limited to physical changes that occur during puberty, pregnancy, abstinence, sexually transmitted infections, and emotional issues.

Please indicate below, your preference concerning your child's participation in these classes and have your child return it to the school.

Should you have any questions, please do not hesitate to contact the school. Thank you for attention concerning this matter.

Student Name: _____

_____ My child has permission to participate in sexual health classes.

_____ My child does not have permission to participate in sexual health classes.

_____
Parent/Guardian signature

Gr. 7-9 Dental program only.

PROVIDENCE
DENTAL HYGIENE

Patient Personal Information

Patient / Student Name: _____ School: _____

Address: _____ City: _____ Postal Code: _____

Phone #: (home) _____ Work: _____ Cell: _____

Date of birth: _____ Age: _____ Gender: _____

Alberta Health Care: _____ Treaty I.D. #: _____

Do you have additional dental insurance through and employer or government agency? (if yes, see below) Yes ___ No ___

Employer: _____

Insurance Policy Information

Account Holder's Name: _____ Date of Birth: _____

Insurance Company Name: _____

Group/Policy #: _____ Cert. #: _____ _____

Parent Email Address _____

I, _____, give my consent to Providence Dental Hygiene and it's providers, to provide preventative dental services and diagnosis (1) on my dependent's behalf. I authorize the release of information concerning my child's healthcare, advice and treatment for the purpose of evaluating and administering claims for insurance benefits. I understand that I am responsible for any co-pay amounts not covered by my work benefit dental insurance and I agree to be responsible for payment of services provided.

Patient / Guardian Signature: _____

1- dental examinations, x-rays, dental cleanings, application of fluoride, sealants (as required)

PROVIDENCE
DENTAL HYGIENE

Medical History

1) **Is your child under the care of a physician at the present?** **YES** **NO**

If yes, since when and why?_____

2) **Has your child ever had a serious illness or been hospitalized?** **YES** **NO**

If yes, please explain:_____

3) **Is your child receiving medication?** **YES** **NO**

Please list the medication: _____

4) **Is your child allergic to any medications, drugs or had a bad reaction to any drug, medicine or food?**

YES **NO**

5) **If yes please list:** _____

6) **Does your child have any limitations to physical activities?** **YES** **NO**

If yes, please explain:_____

7) Does your child have problems: (please circle)

Concentrating Cooperating Learning Understanding

Others: _____

8) Are your child's immunizations up to date? YES NO

9) Have you ever been told that your child has / or has received treatment for any of the following conditions?

(Please circle any that apply)

Allergy	Anemia	Arthritis	Asthma	Autism	Birth Defects
Bleeding	Blood Transfusions	Brain Injury	Cancer	Cerebral Palsy	Chicken Pox
Child Abuse	Cleft Lip/Palate	Developmental Delay	Diabetes	Emotional Disorders	Epilepsy
Eyesight Problems	Fainting	Headaches	Hearing Loss	Heart Trouble	Hemophilia
Hepatitis	**High Blood Pressure**	**Hyperactive**	**Kidney Problems**	**Latex Allergy**	**Leukemia**
Liver Problems	**Lung Problem**	**Malignant Hyperthermia**	**Mentally Challenged**	**Muscular Dystrophy**	**Nutritional Deficiency**
Pneumonia	**Psychiatric Care**	**Scarlet Fever**	**Seizures**	**Speech Problems**	**Tuberculosis**
HIV					

Other: _____

PROVIDENCE
DENTAL HYGIENE

Dental History

1) **Has your child seen a dental professional before?** **YES** **NO**

If so, when (year, month and day)? _____
Name of dentist: _____

2) **Has your child ever had an unpleasant dental experience?** **YES** **NO**

If yes, please explain: _____

3) **Have there been any injuries to the teeth or mouth?** **YES** **NO**

If yes, please explain: _____

4) **Does your child have a toothache or other urgent dental problems?** _____

5) **Is either parent nervous or anxious about their own dental treatment?** **YES** **NO**

6) **Has your child ever received a local anesthetic (freezing)?** **YES** **NO**

Dental Disease Prevention

1) **Does your child use dental floss?** **YES** **NO**

2) Does someone assist your child with tooth cleaning? YES NO

3) Does your child use fluoride containing toothpaste? YES NO

4) Does your child eat sweets, drink soft drinks, or juice (please circle):

More than once a day Once per week Less than once per week

5) How does your child take fluoride supplements at home?

Well Water Fluoride drops or tables Fluoride gel or rinses Not at all

I attest to the accuracy of the information provided on these 2 pages.

Parent's Signature: _____ **Date:** _____

Hygienist's Signature: _____ **Date:** _____

Before you return your child's registration package back to the main office did you:

(Please check off when you have completed each form in the box provided)

	Sign & date all documents
	Submit grade your child is entering for the school year
	Submit a copy of your child's birth certificate (if you have not done so in recent years)
	Submit a copy of guardianship documents (if applicable)
	Submit your child's treaty status number (if applicable)
	Submit your child's Personal Health Care number
	Submit an updated mailing address (include House #)
	Submit updated phone/cell/work numbers
	Make sure that emergency contact information is correct (first & last name/updated phone number/relationship to student)
	Fill out counsellor form (4 pages-double sided) Please do not sign or fill out if you do not want your child to see the counsellor. If you do, please sign and fill out.

John N.A. Janvier School
Box 1680, Cold Lake, AB T9M 1P4
PRINCIPAL: Carmen H. Poitras **EMAIL:** carmen.poitras@tcef.ca

School Counselling Parent Permission Form

Our school counseling program is designed to support the personal, emotional, social, and academic growth of all students in a safe and supportive environment. Counseling services provided may include:

- Individual Counseling: One-on-one sessions addressing specific concerns or challenges.
- Group Counseling: Small group sessions focusing on common themes, such as building friendships, managing emotions, or coping skills.
- Classroom Guidance: Presentations and activities on topics like conflict resolution, emotional regulation, and study skills.
- Crisis Intervention: Immediate support during critical situations.

Confidentiality

Confidentiality is a critical aspect of the counseling relationship. Information shared in counseling sessions is private and will not be disclosed without consent, except in the following situations:

1. The student is at risk of harm to themselves or others.
2. There is suspicion of abuse, neglect, or harm to a child.
3. Legal requirements mandate disclosure.

Parents/guardians will be informed of any concerns affecting the child's safety or well-being.

Consent for Counselling Services

I, the parent/guardian of _____, hereby give my permission for my child to receive counseling services from the counsellor(s) at John N.A. Janvier School.

I understand the following:

- Counseling sessions may occur during school hours.
- Counseling is provided to address social, emotional, and academic needs.
- My child may choose to participate or opt out of counseling services.
- I may contact the school counselor at any time with questions or concerns.

Parent/Guardian Signature: _____ Date: _____

Referral Information

Referral Source (check one):
☐ Teacher
☐ Parent/Guardian
☐ Self-Referral
☐ Administrator
☐ Other: _____

Reason for Referral (optional):

_____

_____

_____

_____

_____

_____

_____

Exchange of Information

Information from counseling sessions will remain confidential in accordance with the Freedom of Information and Protection of Privacy Act (FOIP). Relevant information may be shared with the school's support team (teachers, administrators, etc.) only if it is necessary for the child's success and well-being.

If you have any concerns about information sharing, please contact the school counselor directly to discuss your preferences.