



EDUCATION TOWARDS FREEDOM

2725 ST CHRISTOPHERS ROAD NORTH VANCOUVER BRITISH COLUMBIA CANADA V7K 2B6 TELEPHONE 604 985 7435 FACSIMILE 604 985 4948

APPLICATION FOR ADMISSION GRADE SCHOOL (Grades 1-8)

* This application can only be accepted if all sections on pages 1 & 2 are completed. A photocopy of your child's birth certificate or passport must accompany this form together with a copy of their most recent school report.

Please Print

Grade: Proposed entrance date End Date Student: Legal Name Date of Birth Birthplace Current School Name & Address: Household(s) where your child resides during the school week: Mother Father Guardian

PARENTAL INFORMATION Financial Responsibility: Mother Father Guardian Other Mother: Legal Name Home Address Tel Home: Cell/Pager: Tel Work: Fax: Email: Canadian Citizen Landed Immigrant Native Language Employer: MOTHER'S SIGNATURE I hereby declare all information on this application to be true and correct Year Mth Day Father: Legal Name Home Address If Different Tel Home: Cell/Pager: Tel Work: Fax: Email: Canadian Citizen Landed Immigrant Native Language Employer: FATHER'S SIGNATURE I hereby declare all the information on this application to be true and correct Year Mth Day

Legal Custodial Guardian/Agent: Legal Name _____ Female Male

Home Address _____
PLEASE SPECIFY ACCURATE POSTAL ADDRESS INCLUDING POSTAL CODE

Tel Home: ____ (____) ____ - ____ Cell/Pager: ____ (____) ____ - ____ Tel Work: ____ (____) ____ - ____

Fax: ____ (____) ____ - ____ Email _____
COUNTRY AREA PHONE NUMBER ADDRESS@DOMAIN.COM

Canadian Citizen Landed Immigrant (enclose copy of official document) Native Language _____

If either or both of the parents are deceased, if parents are divorced or separated, please state so and give name and relationship to the pupil of all adults and/or children living in the household.

SIBLING INFORMATION:

Name: _____ School: _____
 Grade: _____ Date of Birth ____ . ____ . ____ Also Applying? Male Female

Name: _____ School: _____
 Grade: _____ Date of Birth ____ . ____ . ____ Also Applying? Male Female

Name: _____ School: _____
 Grade: _____ Date of Birth ____ . ____ . ____ Also Applying? Male Female

Doctor's Name _____ Phone : (____) ____ - ____

Child's Medical Plan Health Number or Insurance Policy Details & Toll Free Number

PROVIDER CHILD'S IDENTIFICATION NUMBER(S) AREA PHONE NUMBER

Authorized Pick Up or Emergency Contact Person _____ Phone: (____) ____ - ____
AREA PHONE NUMBER

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AREA PHONE NUMBER

In case of snow or other extraordinary circumstances in which transportation and/or communication may be interrupted, we need to know where or with whom your child should go.

Early Dismissal Contact Person _____ Phone: (____) ____ - ____
AREA PHONE NUMBER

Do you authorize the Vancouver Waldorf School to take care of your child during an emergency if we are unable to contact you? This may include transportation to the hospital and basic first aid.

Yes No **Parent/Guardian Signature(s)** _____
SIGNATURE SIGNATURE

IMPORTANT: *Your Application Can Only Be Processed If The Information On This Page Is Complete Or Special Arrangements Have Been Made With Our Enrollment Coordinator.*

For office use only: Received _____ App. fee \$ _____ To teacher _____
YEAR MTH DAY YEAR MTH DAY

PART II MEDICAL INFORMATION

Does your child have any medical conditions? Please describe together with any treatments.

Please state any known allergies (food/animal/medication).

Does your child have any physical challenges?

Any special fears?

Other health information:

Give a brief evaluation of your child's health.

Has your child recently had a hearing test? Yes No
 Been diagnosed with a hearing problem? Yes No History of Chronic ear infections? Yes No
 Has your child recently had a test for vision? Yes No Known Vision problems? Yes No
 Does your child wear glasses or contacts? Yes No

Comments: _____

Please check the appropriate boxes if your answer is 'yes' to any of the questions in the following three columns:

Has your child had any of the following illnesses? Or ever been immunized for any of the following illness?	Has your child had any of the following illnesses or conditions?	Has your child ever experienced any of the following?
Chicken pox <input type="checkbox"/> <input type="checkbox"/> . <small>ILLNESS IMMUNIZED YEAR MTH</small>	<input type="checkbox"/> Asthma	<input type="checkbox"/> Concussion
Red Measles (Rubeola) <input type="checkbox"/> <input type="checkbox"/> . <small>ILLNESS IMMUNIZED YEAR MTH</small>	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Major Surgery
German Measles (Rubella) <input type="checkbox"/> <input type="checkbox"/> . <small>ILLNESS IMMUNIZED YEAR MTH</small>	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Admission to Hospital
Mumps <input type="checkbox"/> <input type="checkbox"/> . <small>ILLNESS IMMUNIZED YEAR MTH</small>	<input type="checkbox"/> Diabetes	
Whooping Cough <input type="checkbox"/> <input type="checkbox"/> . <small>ILLNESS IMMUNIZED YEAR MTH</small>	<input type="checkbox"/> Epilepsy	
Poliomyelitis <input type="checkbox"/> <input type="checkbox"/> . <small>ILLNESS IMMUNIZED YEAR MTH</small>	<input type="checkbox"/> Convulsions/Fits	
Diphtheria <input type="checkbox"/> <input type="checkbox"/> . <small>ILLNESS IMMUNIZED YEAR MTH</small>		
Tetanus <input type="checkbox"/> <input type="checkbox"/> . <small>ILLNESS IMMUNIZED YEAR MTH</small>		
Haemophilus B <input type="checkbox"/> <input type="checkbox"/> . <small>ILLNESS IMMUNIZED YEAR MTH</small>		
Hepatitis B <input type="checkbox"/> <input type="checkbox"/> . <small>ILLNESS IMMUNIZED YEAR MTH</small>		

Comments: _____

At birth was your child ... Premature? <input type="checkbox"/> Yes <input type="checkbox"/> No Very small? <input type="checkbox"/> Yes <input type="checkbox"/> No Given special care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your child receiving ... Medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Medical attention? <input type="checkbox"/> Yes <input type="checkbox"/> No Psychological help? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child suffer from ... Hyperactivity? <input type="checkbox"/> Yes <input type="checkbox"/> No Dyslexia? <input type="checkbox"/> Yes <input type="checkbox"/> No Other learning disability? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Comments: _____

PART III INFORMATION

By what name does the pupil address? Mother: _____ Father: _____ Guardian: _____

What languages are ordinarily spoken in the home? _____

What is your interest in Waldorf Education?

What is your understanding of Waldorf Education?

Why are you choosing Waldorf Education for your child?

Students Subjects enjoyed most _____

Students Subjects enjoyed least _____

What activities outside school (hobbies, programs etc) does your child participate in?

Average hours of TV viewing: Daily _____ Weekends: _____

Average hours of Music/Radio: Daily _____ Weekends: _____

Average hours of Computer Games: Daily _____ Weekends: _____

What do you consider to be your child's strongest aptitudes and traits of character?

What are your hopes and desires for your child attending our school?

Do you have any further comments or concerns that would help us in our work with your child?
(Include professional or therapeutic support)

Mother: Interests/Hobbies/Talents: _____

Father: Interests/Hobbies/Talents: _____

Personal information will be used and disclosed* in accordance with the privacy protection provisions of the Personal Information Protection Act (PIPA British Columbia). If you have any questions about the collection, use and disclosure of this information, consult the Vancouver Waldorf School Personal Information Privacy Policies in the Parent Handbook or contact the Privacy Officer, Vancouver Waldorf School, (604) 985-7435 ext 223.
***This includes the publication of personal information in the Vancouver Waldorf School's community phonebook.**