

GRADE 7 (2020 – 2021)
ARTHUR DAY MIDDLE SCHOOL
RIVER EAST TRANSCONA SCHOOL DIVISION
SCHOOL REGISTRATION APPENDIX

STUDENT'S LEGAL NAME: _____
(Last) (First) (Middle)

SECTION A: STUDENT COURSE REQUIREMENTS

1. All students will be taking the required courses as set out by the Department of Education and the School Division.
2. Students have the option of choosing **BAND** or **ART**. For Band, you ***must*** rent or own an instrument.

Check one: **BAND** **ART**

SECTION B: PREVIOUS SCHOOLING

1. Has your child ever attended a special program (not including the support services identified on the main registration form)? YES NO

If YES, which one(s)?

- | | |
|---|---|
| <input type="checkbox"/> Reading Tutor | <input type="checkbox"/> Resource Tutoring |
| <input type="checkbox"/> Reading Recovery | <input type="checkbox"/> LAR (behavior support classroom) |
| <input type="checkbox"/> Developmental Teaching | <input type="checkbox"/> Other (specify) _____ |

2. Has your child ever been funded? YES NO

If YES: Current Past Level II Level III

3. Last school attended: _____ Grade: _____
City: _____ Province: _____

SECTION C: ADMINISTRATION OF MEDICATION

Will your child need to take medication other than an inhaler or epi-pen at school? YES NO

If YES, what is the medication? _____

How often will it need to be administered? _____

Doctor's Name _____ Doctor's Phone: _____

SECTION D: VISION AND HEARING

- | | | |
|--|------------------------------|-----------------------------|
| Does your child wear corrective lenses (glasses or contact lenses)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Does your child have a history of vision-related concerns? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Does your child require and use devices to facilitate their hearing? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Does your child have a history of hearing-related concerns? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Parent/Guardian Signature: _____ Date: _____

NOTE: If any of the above information changes during the year, please send a note or call the school.

Please return by Monday, March 2, 2020

ARTHUR DAY MIDDLE SCHOOL HEALTH CARE INFORMATION

This form is to be used when a student registers and may be used to determine if a student requires health care support at school.

NAME: _____	MB Medical No. (9 digit): _____
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1. Does your child have allergies? YES NO

If YES, please list the specific allergies:

2. Does your child have an Epi-Pen? YES NO
(If YES, your child must carry the epi-pen at all times)

3. Does your child take medication for asthma (inhaler/puffer)? YES NO

Note - If there is any chance that your child may use the inhaler at school, they must have the appropriate documentation completed and submitted to the school.

4. Will your child need to take medication at school? YES NO

If YES, what is the medication? _____

How often will it be needed? _____

5. Does your child have seizures? YES NO

If YES, when was the last seizure? _____

6. Does your child have any other health concerns that the school needs to be aware of? (i.e. diabetes, migraines, heart condition, etc.). If so, please list.
