



**SWAN VALLEY SCHOOL DIVISION
Student Enrollment Form**

MET#

Cum File Request

This personal information is being collected under the authority of the Public Schools Act/Education Administration Act and will be used for the purpose of educating your child. It is protected by the Protection of Privacy provisions of The Freedom of Information and Protection of Privacy Act and the Personal Health Information Act. If you have any questions regarding the collection, please contact your school.

SCHOOL INFORMATION

School Name: _____ **Previous School Name:** N/A
Entry Date: 2026-2027 **Entry Grade:** K **Home Room:** _____

TUITION INFORMATION

Frontier School Division Good Spirit School Division Sapotaweyak Cree Nation
 Wuskwi Sipiik First Nation Other: Please Specify

STUDENT INFORMATION

Legal Name: _____ **Legal Gender:** M F
Preferred Name: _____ **Preferred Gender:** M F X
Birthdate: _____ **Treaty Number:** _____
Mobile Number: _____ **Personal Email:** _____
Physical Address: _____
Mailing Address: _____
Second Mailing Address: _____

RESIDENCY INFORMATION

Residing with someone other than a legal guardian (Responsible Adult)

CUSTODY INFORMATION

Care of Child and Family Services **Agency:** _____
 Agency has completed a School Registration Form Child in Care from Healthy Child Manitoba.
 A custody agreement exists and has been provided to the school.
 Name(s) of individual(s) denied access by the court has been provided to the school.

MEDICAL INFORMATION

MB Health: _____ **PHIN:** _____ **Family Doctor:** ~
Does your child have... **Doctor Phone:** _____

a non-life-threatening allergy?
 medications to be administered at school?
 a physical challenge/disability?

Please complete the following URIS Group B medical/health information. This personal information or personal health information is being collected under the authority given to the Swan Valley School Division under The Public Schools Act and will be used for educational purposes or to ensure the health and safety of the student. It is protected by The Freedom of Information and Protection of Privacy Act (including, but not limited to, section 37) and The Personal Health Information Act (including, but not limited to, Part 3, Division 1). If you have any questions about the collection, contact the Swan Valley School Division office (204)734-4531.

Please check "Yes" or "No" for each health care need:

<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Anaphylaxis	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Clean intermittent catheterization	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Ostomy care
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Asthma	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Diabetes	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Pre-set oxygen
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Bleeding disorder	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Gastrostomy care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Seizure disorder
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Cardiac condition	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Osteogenesis imperfecta	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Suctioning (oral/nasal)

AUTOMATED COMMUNICATION

Primary Phone Number:	Secondary Phone Number:
Primary Text Number:	Secondary Text Number:
Primary Email:	Secondary Email:

CONTACT 1

Name:		Relationship:			
Employer:		Email:			
1	Work:	<input checked="" type="checkbox"/>	Storm Billet	<input checked="" type="checkbox"/>	School Pickup
2	Home:	<input checked="" type="checkbox"/>	Custody	<input checked="" type="checkbox"/>	Emergency Contact
3	Mobile:	<input checked="" type="checkbox"/>	Lives With	<input checked="" type="checkbox"/>	Data Access

CONTACT 2

Name:		Relationship:			
Employer:		Email:			
1	Home:	<input checked="" type="checkbox"/>	Storm Billet	<input checked="" type="checkbox"/>	School Pickup
2	Mobile:	<input checked="" type="checkbox"/>	Custody	<input checked="" type="checkbox"/>	Emergency Contact
3	:	<input checked="" type="checkbox"/>	Lives With	<input checked="" type="checkbox"/>	Data Access

CONTACT 3

Name:		Relationship:			
Employer:		Email:			
1	Mobile:	<input checked="" type="checkbox"/>	Storm Billet	<input checked="" type="checkbox"/>	School Pickup
2	Home:	<input checked="" type="checkbox"/>	Custody	<input checked="" type="checkbox"/>	Emergency Contact
3	:	<input checked="" type="checkbox"/>	Lives With	<input checked="" type="checkbox"/>	Data Access

CONTACT 4

Name:		Relationship:			
Employer:		Email:			
1	Mobile:	<input checked="" type="checkbox"/>	Storm Billet	<input checked="" type="checkbox"/>	School Pickup
2	Home:	<input checked="" type="checkbox"/>	Custody	<input checked="" type="checkbox"/>	Emergency Contact
3	:	<input checked="" type="checkbox"/>	Lives With	<input checked="" type="checkbox"/>	Data Access

CONTACT 5

Name:		Relationship:			
Employer:		Email:			
1	Work:	<input checked="" type="checkbox"/>	Storm Billet	<input checked="" type="checkbox"/>	School Pickup
2	:	<input checked="" type="checkbox"/>	Custody	<input checked="" type="checkbox"/>	Emergency Contact
3	:	<input checked="" type="checkbox"/>	Lives With	<input checked="" type="checkbox"/>	Data Access

SIBLING INFORMATION

	Name of Sibling	Gender	Date of Birth	School Attending	Grade
1					
2					
3					
4					

INDIGENOUS IDENTITY DECLARATION

Indigenous Identity Declaration helps to support the efforts of Manitoba Education and Training and school divisions to plan and improve programs in a way that is responsive to Indigenous learners. (Providing this personal information is voluntary and optional. It is being collected in compliance with section 36(1)(b) of The Freedom of Information and Protection of Privacy Act as it is necessary for and relates directly to the activity of Manitoba and school divisions to plan, deliver and improve programs.)

- I am submitting my child's Indigenous Identity Declaration for the first time.
- I am making changes to my child's Indigenous Identity Declaration.
- I already submitted my child's Indigenous Identity Declaration and have no further changes to make at this time.

INDIGENOUS SELF-DECLARATION

Is your child an Indigenous person, that is, First Nation (North American Indian), Métis, or Inuk (Inuit)? Note: First Nations (North American Indian) include Status and Non-Status Indians. If "Yes" mark the square(s) that best describe(s) your child now:

- Yes, First Nation (North American Indian)
- Yes, Métis
- Yes, Inuk (Inuit)

LINGUISTIC AND CULTURE GROUPS

*Which best describes your child's Indigenous cultural-linguistic identity?
Please select up to two choices:*

- | | | | |
|-------------------------------------|---------------------------------|-------------------------------------|-----------|
| <input checked="" type="checkbox"/> | Anishinaabe (Ojibway/Saulteaux) | | |
| <input checked="" type="checkbox"/> | Dene (Sayisi) | <input checked="" type="checkbox"/> | Ininiw |
| <input checked="" type="checkbox"/> | Dakota | <input checked="" type="checkbox"/> | Inuktitut |
| <input checked="" type="checkbox"/> | Oji-Cree | <input checked="" type="checkbox"/> | Michif |
| <input checked="" type="checkbox"/> | Other | Please specify | |

MEDIA RELEASE

The Swan Valley School Division recognizes that print, digital media and the internet as well as the news media, provide ideal means to showcase and promote School and Divisional activities and share student work with other students, parents/guardians, staff and the global community.

At the same time however, the Division remains committed to the protection, privacy and safety of all students. For this reason, the Division has established Administrative Procedure 405: Media Relations and Media Release.

Identification and publication may take place via photo, print, video, websites or any other Divisionally sanctioned online collaboration, sharing or publishing platform, whether accessed through the web, a mobile device, text messaging, email or any other existing or emerging communications platform.

Y N I give permission for my child's photo to be taken by a vendor for the purpose of annual school pictures and yearbook if available along with print, digital media, the internet as well as the news media.

Y N I give permission for my child's photo to appear in school publications (i.e. newsletters, promo-materials and website).

Y N I give permission for my child's photo to appear in school-based social media (names of children are not included in any distribution).

AUTHORIZATION

To the best of my knowledge, the information provided on this form is true and accurate.

Print Name

Signature

Date

Kindergarten Orientation Parent Questionnaire

Welcome to Kindergarten! As parents, you have a deep understanding of your child and the information you provide will help us better meet your child's needs. All children come to kindergarten with diverse experiences and at different levels of development. Information from this questionnaire will serve to support your child's transition to school.

Thank you for taking the time to complete this information.

Child's Name: _____

Date of Birth: _____

Name of Parent(s)/Guardian(s):

1. _____

2. _____

Name of Sibling(s)/Grade:

1. _____ / _____

2. _____ / _____

3. _____ / _____

Name of Caring Agency:

Contact Person: _____

Phone Number: _____

Are both parents/guardians residing with the child?

- Yes
- No

If no, please indicate where the child resides during the school week:

Arrival at School

My child will be accompanied to school by:

- Parent
- Caregiver
- Sibling
- Bus (Bus # if known _____)
- Other _____

Departure from School

My child will be picked up by:

(please provide the full name if known)

- Parent _____
- Caregiver _____
- Sibling _____
- Bus (Bus # if known _____)
- Other _____

Health Information:

Does your child have any health problems/ conditions/illnesses or allergies?

(please describe in detail)

- born premature
- prenatal concerns
- previous referral to CDC, SSCY, St. Amant, CLDs, geneticist, other *(If yes, please discuss further with the teacher)*

Is your child on any medications?

- Yes *(If yes, please discuss further with the teacher to ensure we know what to look for if medication is missed or a reaction occurs.)*
- No

Additional Information:

To your knowledge does your child have any speech or language concerns, a history of ear infections or hearing difficulties, vision problems or trouble sleeping?

- Yes *(if yes, please explain)*
- No

What time does your child typically go to bed? _____

Please indicate what pre-school experiences your child has had. *(check all that apply)*

- Child Care Centre
- Child's home *(parent or other relative)*
- Child's home *(non-relative, i.e. nanny)*
- Play Group
- Nursery School
- Parent & Tot
- Better Beginnings
- Head Start
- Baby & Me
- Limited Pre-School Experience
- Other _____

Did your child receive preschool therapy services through Jordan's Principle? *(i.e., Speech Language Therapy, Occupational Therapy, Physical Therapy)*

- Yes *(if yes, please explain)*
- No

Has your child received any support from Jordan's Principle that pertains to school?

- Yes *(if yes, please explain)*
- No

Are there situations in which your child becomes particularly excitable, upset, frightened or angry? (e.g., dogs, being alone, loud noises, etc.)

- Yes (if yes, please explain)
- No

Has your child experienced any significant changes in their family life in the past? (e.g., death, separation, birth of a baby, family illness)

- Yes (if yes, please explain)
- No

Has your child experienced stomach problems, bowel or bladder problems?

- Yes (if yes, please explain)
- No

Please indicate whether your child uses the toilet independently or with support.

- Independently
- With support (if with support, please explain)

Indicate whether your child is independent with the following: (check all that apply)

- Dressing
- Laces
- Snaps
- Buttons
- Zippers
- Putting on/taking off shoes
- Opening containers for snack
- Opening wrappers and packages

Is there anything I should know to better understand your child? (e.g., likes, dislikes, daily routines)

Check off the characteristics that describe your child's personality?

- shy
- talkative
- independent
- outgoing
- quiet
- generous
- friendly
- aggressive
- sensitive
- with-drawn
- helpful

What motivates your child? (in activities, play, chores, etc.)-*please explain*

What bothers or frustrates your child? What strategies have been effective when dealing with this?
Please explain

Please tell me 1-3 things your child is interested in.

- ❖ _____
- ❖ _____
- ❖ _____

What is your child looking forward to when they come to school? *(please explain)*

Are there any concerns for your child or yourself? *(please explain)*

What activities do you and your child like to do together?

What is your child's favorite play activity or toy? (e.g., favorite TV program, board game, play activity)

Would you enjoy helping in our classroom? _____

What would you enjoy doing? *Please indicate*

- Help with special activities, arts and crafts
- Help on classroom/school field trips
- Other _____

Please list any holidays or special celebrations your child would like to share with the class?

Please indicate if your child does not celebrate specific holidays.

- Are there cultural or religious factors that we should be aware of?



UNIFIED REFERRAL AND INTAKE SYSTEM (URIS) GROUP B APPLICATION (a)

Review application, complete and sign in ink

The purpose of this form is to identify the child's specific health care and if applicable, apply for URIS Group B support which includes the development of a health care plan and training of community program staff by a registered nurse. URIS is a partnership of Health, Education and Family Services. If you have questions about the information requested on this form, you may contact the community program.

Section I – To be completed by the community program

Type of community program (please ✓) <input type="checkbox"/> School <input type="checkbox"/> Licensed child care <input type="checkbox"/> Respite <input type="checkbox"/> Recreation program <input type="checkbox"/> Other: _____ _____	Community Program Name: _____	Location of Service: <input type="checkbox"/> Same as on left
	Contact person: _____	Contact person: _____
	Phone: _____ Fax: _____	Phone: _____ Fax: _____
	Email: _____	Email: _____
	Mailing address: Street address: _____ City/Town: _____ Postal Code: _____	Mailing address: Street address: _____ City/Town: _____ Postal Code: _____

Section II - Child information - to be completed by parent

Last Name	First Name	Birthdate
		Y Y Y Y M M M D D

Preferred Name (Alias)	Age	Grade	Gender	
				M <input type="checkbox"/> F <input type="checkbox"/> Other <input type="checkbox"/>

Does your child ride the bus? YES NO

Does your child have any of the following listed health concerns? YES NO (check (✓) one)

➤ If you have answered **NO**, please sign here and return this form to the community program.

Parent/ Legal Guardian NAME	Parent/Legal Guardian SIGNATURE	DATE (YYYY/MMM/DD)
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- If you have answered **YES**, please complete the remainder of the form **including Section III**.
- Please check (✓) all health care conditions for which the child requires an intervention during attendance at the community program. Return the completed form to the community program.

<input type="checkbox"/> YES <input type="checkbox"/> NO	Life-threatening allergy and child is prescribed an injector (e.g. Epi-Pen®/ Taro Epinephrine®/ Allerject®)	<input type="checkbox"/> YES <input type="checkbox"/> NO Does the child bring an injector to the community program?
<input type="checkbox"/> YES <input type="checkbox"/> NO	Asthma (administration of medication by inhalation)	<input type="checkbox"/> YES <input type="checkbox"/> NO Does the child bring reliever medication (puffer) to the community program? <input type="checkbox"/> YES <input type="checkbox"/> NO Does your child know when to take their reliever medication (puffer) e.g. can recognize signs of asthma? <input type="checkbox"/> YES <input type="checkbox"/> NO Can your child take their reliever medication (puffer) on their own ? IF NO, describe what your child needs help with: _____
<input type="checkbox"/> YES <input type="checkbox"/> NO	Seizure disorder What type of seizure(s) does the child have? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO Does the child require administration of rescue medication? <input type="checkbox"/> Lorazepam <input type="checkbox"/> Midazolam <input type="checkbox"/> YES <input type="checkbox"/> NO Does the child require the use of a vagal nerve stimulator (wand)?
<input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes What type of diabetes does the child have? <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	<input type="checkbox"/> YES <input type="checkbox"/> NO Does the child require blood glucose monitoring at the community program? <input type="checkbox"/> YES <input type="checkbox"/> NO Does the child require assistance with blood glucose monitoring? <input type="checkbox"/> YES <input type="checkbox"/> NO Does the child have low blood glucose emergencies that require a response?

<input type="checkbox"/> YES	<input type="checkbox"/> NO	Ostomy Care	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child have an ostomy/stoma?
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child require the ostomy pouch to be emptied at the community program?
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child require the established appliance to be changed at the community program?
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child require assistance with ostomy care at the community program?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Gastrostomy Care	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child have a gastrostomy tube? Type of tube: _____
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child require gastrostomy tube feeding at the community program?
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child require administration of medication via the gastrostomy tube at the program?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Clean Intermittent Catheterization (CIC)	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child require CIC?
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child require assistance with CIC at the community program?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Pre-set Oxygen	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child require pre-set oxygen at the community program?
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child bring oxygen equipment to the community program?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Suctioning (oral and/or nasal)	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child require oral and/or nasal suctioning at the community program?
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child bring suctioning equipment to the community program?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Cardiac Condition where the child requires a specialized emergency response at the community program.	
			What type of cardiac condition has the child been diagnosed with? _____
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Bleeding Disorder (e.g., von Willebrand disease, hemophilia)	
			What type of bleeding disorder has the child been diagnosed with? _____
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Endocrine Conditions (e.g. steroid dependence, congenital adrenal hyperplasia, hypopituitarism, Addison's disease)	
			What type of steroid dependence has the child been diagnosed with? _____
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Osteogenesis Imperfecta (brittle bone disease)	What type? _____

Section III - Authorization for the Release of Medical Information

In accordance with *The Personal Health Information Act (PHIA)*, I authorize the Community Program, the Unified Referral and Intake System Provincial Office, and the nursing provider serving the community program, all of whom may be providing services and/or supports to my child, to exchange and release medical information specific to the health care interventions identified above and consult with my child's health care provider, if necessary, for the purpose of developing and implementing an Individual Health Care Plan/Emergency Response Plan and training community program staff for

Child's Name: _____ **Child's PHIN:** _____

I also authorize the Unified Referral and Intake System Provincial Office to include my child's information in a provincial database which will only be used for the purposes of program planning, service coordination and service delivery. This database may be updated to reflect changing needs and services. I understand that my child's personal and personal health information will be kept confidential and protected in accordance with *The Freedom of Information and Protection of Privacy Act (FIPPA)* and *The Personal Health Information Act (PHIA)*.

I understand that any other collection, use or disclosure of personal information or personal health information about my child will not be permitted without my consent, unless authorized under FIPPA or PHIA.

Consent will be reviewed with me annually. I understand that as the parent/legal guardian I may amend or revoke this consent at any time with a written request to the community program.

If I have any questions about the use of the information provided on this form, I may contact the community program directly.

NAME (PRINT) Parent/ Legal Guardian **SIGNATURE Parent/Legal Guardian** **DATE (YYYY/MMM/DD)**

Mailing Address: _____ City/Town: _____ Postal Code: _____

Work/Daytime Phone: _____ Cell Phone: _____ Home Phone: _____

Email: _____