



KAHNAWÀ:KE EDUCATION SYSTEM APPLICATION FORM

PO Box 1000
Kahnawà:ke QC J0L 1B0
Tel: 450 632-8770 Fax: 450 632-8042 www.kecedu.ca



Karonhianónhnha School _____ Kateri School _____ Kahnawake Survival School _____ School Year _____

Section 1 - Student Identification

Last Name: _____ Given Name: _____

Kanien'kéha Name: _____ Band Number: (TEN DIGIT #) _____

Birth Date: Month _____ Day _____ Year _____ Male _____ Female _____ Clan: _____

Address/PO Box: _____ Town/City #: _____

Postal Code: _____ Telephone #: _____

Language(s) spoken at home: Kanien'kéha English French Other: _____

Previous School attended: _____ Grade: _____ Year: _____

Section 2 - Parent / Guardian Information

Father's Last Name: _____ Mother's Maiden Name: _____

Father's First Name: _____ Mother's First Name: _____

Father's Box #: (if different from child's) _____ Mother's Box #: (if different from child's) _____

Home Telephone #: _____ Home Telephone #: _____

Cell Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Work Phone #: _____

Email: _____ Email: _____

Child resides with: Mother Father Both Parents Shared Custody Guardian

Section 3 - Emergency Contacts - OTHER THAN PARENT/GUARDIAN

Emergency Contact: _____ Emergency Contact: _____

Home Telephone #: _____ Home Telephone #: _____

Cell Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Work Phone #: _____

Relationship to student: _____ Relationship to student: _____

Sibling(s) currently attending Karonhianónhnha, Kateri or Survival School:

Name: _____ School: _____ Grade: _____

Name: _____ School: _____ Grade: _____

Name: _____ School: _____ Grade: _____

I authorize the use of photos, videos, voice recordings, accomplishments and/or similar items of my child in Kahnawake Education System publications or as part of any media events, such as radio, newspaper, television, website, etc. Yes No

I volunteer to assist in any scheduled social, recreational or educational activity and can be contacted using the information above.

Person(s) authorized to pick up your child (other than yourself):

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Person(s) NOT authorized to pick up your child (Legal Documentation Required):

Name: _____ Relationship: _____
Name: _____ Relationship: _____

Medical Information:

Medicare #: _____ Name on Card: _____ Expiry Date: _____

Allergies: No _____ Yes _____ Specify to what: _____ EPIPEN required? No ___ Yes _____

Physical or Medical Problems: No _____ Yes _____ Describe: _____

Medication Required? No _____ Yes _____ Type of Medication: _____ Dosage: _____

Please fill in the dates of your child's shot in the spaces provided below. We require having your child's immunization records in the event of an infectious disease outbreak, for example, the school nurse can then easily determine the proper measures to protect your child and/or others; as well as ensuring that your child is up to date with their immunizations. If you do not have this information, please go to the place where your child has been previously immunized to obtain a copy.

Diphtheria - Tetanus - Pertussis - Poliomyelitis (Polio) - Haemophilus Influenza Type B:

Measles - Mumps - Rubella - Chicken Pox (Varicella):

Meningococcal Infection:

Pneumococcal Infection:

Other (please specify):

Bussing Information:

** Please describe the home location of the registered child for bussing purposes (i.e. Blind Lady's Hill, Clay Mountains, etc.).

Home location of registered child:

* For safety/emergency reasons, parent names and emergency contact information will be provided to the MCK Transport department. All information will be handled confidentially and used for valid purposes only.

I, the undersigned, attest that all the above information is correct, and I acknowledge that I am responsible for notifying the school of any changes to the above information concerning my child.

Parent/Guardian Signature

Date

**Please return completed application form, a copy of child's BIRTH CERTIFICATE and MEDICARE CARD to:
Tracey Alfred, Registrar, Kahnawà:ke Education Center**



Kahnawà:ke Education System

PO Box 1000
Kahnawake QC J0L 1B0
Tel: 450 632-8770 Fax: 450 632-8042 www.kecedu.ca



AUTHORIZATION FOR RELEASE OF INFORMATION

STUDENT IDENTIFICATION

Family Name: _____ First Name: _____
 Band Number: _____ Date of Birth: _____
(mm/dd/yy)
 Permanent Code: _____ Grade: _____

AUTHORIZATION

I, the undersigned parent or guardian, with respect to confidentiality, authorize the school identified below to send all relevant information and records including all academic and psycho-educational assessments, education and behaviour programs (IEP's), behaviour and attendance records about the identified student.

Release from _____ Phone: _____
(School/Institution)

Fax: _____

Release to: Kahnawà:ke Education Center c/o (check below) Phone: 450 632-8770

(Karonhianonhnha School Kateri School Survival School) Fax: 450 632-8042

Parent/Guardian: _____ Phone: _____

Signature: _____ Date: _____

You have the right to refuse to authorize the release of information. You have the right to cancel your permission; you may do so in writing, which will take effect immediately unless the information was released prior to your retraction. You have a right to receive a copy of this release of information authorization.

For Office Use Only

KEC Contact: _____ Phone: 450 632-8770

Signature: _____ Date: _____

