



WESTPARK SCHOOL

B2375 Saskatchewan Avenue West

Portage la Prairie, MB R1N 4A6

Phone: 204-857-3726 / Fax: 204-239-6545

Website: www.westparkschool.com / Email: office@westparkschool.com

Academics for today; Character for tomorrow; Jesus forever

Re-Enrollment Application for Admission

For Office Use

Application/Tuition Deposit

Received Date

Student Information

Legal Name of Student: _____ Registering for Grade: _____

(Legal Last Name)

(Legal First Name)

(Legal Middle Name)

(Birth Date MM/DD/YYYY)

Student Address: _____

(Mailing Address)

(Postal Code)

(Home Phone #)

Student Manitoba Medical # (9-digit) _____ Student Family # (6-digit) _____

Student lives with (Check all that apply):

Father

Mother

Legal Guardian

Foster Parents

Other

Father/Guardian: _____

(First Name/Last Name)

(Email)

(Cell #)

(Place of Employment)

(Work Phone #)

(Church Affiliation)

Mother/Guardian: _____

(First Name/Last Name)

(Email)

(Cell #)

(Place of Employment)

(Work Phone #)

(Church Affiliation)

Joint Custody – Additional Student Address: Father Mother

Student Address: _____

(Mailing Address)

(Postal Code)

(Home Phone #)

**Please Note: Copy of legal documentation regarding custody must be provided to the school*

Custody: Are there any legal restrictions to this student?

Send additional report card?

Emergency Contacts

If the listed Parents/Guardians are unavailable during an emergency, the school should call:

Emergency contacts must live within 30 minutes of the school

1) _____
(Relationship to Student) (Name) (Day Time Phone #)

2) _____
(Relationship to Student) (Name) (Day Time Phone #)

Aboriginal/Indigenous Identity Declaration

Aboriginal/Indigenous Identity Declaration helps to support the efforts of Manitoba Education and Advanced Learning and school divisions to plan and improve programs in a way that is responsive to Aboriginal/Indigenous learners. The information you provide is collected in compliance with section 36(1)(b) of The Freedom of Information and Protection of Privacy Act. Providing this information is voluntary and optional. For more information about Aboriginal/Indigenous Identity Declaration, please visit: <http://www.edu.gov.mb.ca/aed/abidentity.html>. If you have any questions regarding the collection of this personal information, please contact the school principal.

Please check one of the following identities, if it applies to your child: (These include Status and Non-Status Indians)

- Aboriginal/Indigenous First Nation Metis Inuit

If you have selected an Aboriginal/Indigenous identity, please check up to two of the following cultural linguistic identities that best describe your child:

- Anishinaabe (Ojibway/Saulteaux) Oji-Cree
 Ininew (Cree) Michif
 Dene (Sayisi) Inuktitut
 Dakota Other _____

Student Health Information

Does the student have a diagnosed health condition?

- Asthma Hard of Hearing Diabetes
 Inhaler Seizures Vision
 Allergy _____ EpiPen

Other, please specify: _____

***Please note: Any medication needed to be administered during the school day, must be kept in the school office.**

Any other information the school should have about the student's health: _____

Child's Doctor: _____ Phone Number: _____

Parent/Guardian Signature

Re-Enrolment application must include:

- Tuition Deposit - \$100 (per student) URIS (if applicable)
 Off Campus Privileges (Gr. 9 to 12)

I have read and understand the statements of Westpark School's philosophy and objectives and policies as stated in the information manual (available at www.westparkschool.com).

- I agree to support the school in applying these principles in the teaching of my child.
- If my child is accepted, I will support him or her and Westpark School.
- The information in this application is accurate to the best of my knowledge.

Initial please _____ *I give permission for members of the media and staff, at the discretion of the Principal, to take pictures/video of my child. Photos may be used for School promotion or on the website.

Signatures of (both) Parents / Guardians:

Father/Guardian _____ Date: _____
MM/DD/YYYY

Mother/Guardian _____ Date: _____
MM/DD/YYYY

**NOTE: Submission of application form does not guarantee enrolment.
The leadership team will make final admission decision**



Westpark School Tuition and Fee Calculation Form

Tuition and Fee Information for 2024/2025 School Year (One per Family)

Name: _____

Phone Number: _____

Number of Children enrolled (Kindergarten = 0.5): _____

BOX A – Tuition Costs

	Cost Per Student Until April 15 th , 2024	Cost Per Student After April 15 th , 2024	Number of Students	Total
Kindergarten (3 Day)				
Grade 1 – 4				
Grade 5 – 8				
Grade 9 – 12				
Subtotal				

Family Discounts: Kindergarten (0.5 per student) Grades 1 – 12 (1 per student)

Number of Children in School	Discount	
1.5	\$275	
2	\$550	
2.5	\$825	
3	\$1,100	
3.5	\$1,375	
4	\$1,650	
4.5	\$1,925	
5 or more	\$2,200	
Discount Applicable (select based on chart)		

Net Tuition Costs after Family Discount	
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Capital Improvement Fee per year:

\$200 per family

This fee goes towards the capital expenses that the school needs to keep and maintain the facility (things in the building, not books). Capital fees do not go toward new building construction. They are supplemented by budgeted money from the general fund of the school. The Capital Fee provided throughout is 100% tax deductible and is included with the tuition portion on your annual tax receipt.

Student Fees per year:

\$75 – Kindergarten

\$125 – Students from Grades 1 to 12

These fees cover the cost of school supplies provided to students as well as field trips for the year. Please note, you will not be reimbursed for activities if your child does not attend.



Westpark School Tuition and Fee Calculation Form

Tuition and Fee Information for 2024/2025 School Year (One per Family)

BOX B

1. Tuition (per chart in Box A on front)			
2. Capital Fee (per family)			+
3. Student Fees	Kindergarten	x students	+
	Grades 1 – 12	x students	+
4. Total Tuition, Capital, and Student Fees (#1 + #2 + #3)			=
5. Less Early Payment Discount if paying in full before June 30 th , subtract 5% of line 1 for discount			-
6. Total Payable (#4 - #5)			=

Non-Refundable Tuition Deposit of \$100 per student due with enrolment forms. **
(Deposit will be applied to total payable.)

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Total Tuition Deposit of \$100 per student paid:

BOX C

Indicate your Tuition Payment Choice:

- Lump Sum Payment**
- Pre-authorized Debit (Complete PAD authorization in Box D)
- I am requesting a tuition assistance information and application package (Tuition Deposit Required)

BOX D

Pre-Authorized Payment Option

- Keep banking information the same as previous year. Change the amount only.

Bank Information

- Option #1:** I will supply a void cheque
- Option #2:** Fill out bank information below (All info is required)

Name of Institution: _____ Branch Address: _____

City/Province: _____

Transit #: (5 digits) _____ Institution #: (3 digits) _____

Account #: (7+ digits including all zeros) _____

Frequency of Payment

- Bi-Weekly (Every other Friday)
- Semi-Monthly (1st and 15th only)
- Monthly (1st or 15th)

Payment Amount: _____ (Total payable from Box B Line #6 divided by number of payments)

Start Date: _____ End Date: _____

*** Tuition payments for this school year must be completed on or before June 30th ***

****Credit card processing fee of 3% will be added****



WESTPARK SCHOOL

Off Campus Privileges

Dear Parents/Guardians;

Off-campus privileges during lunch or a spare are available to students in **grades 9 through 12** who have parental consent. This may be suspended by a Parent, or the Administration, if a student is consistently late returning from off-campus, or has more than 3 unexcused absences, or is receiving a failing grade in any class.

Signing this agreement indicates that you have read and understand Off-campus privileges.

I have read and understand this privilege and give my child permission to leave campus during a spare or lunch. I waive all responsibilities of the school and will not hold the school negligent should my child be injured while utilizing this privilege.

Student Grade: _____

Student Name (Please Print): _____

Parent Signature: _____

Westpark School

B2375 Saskatchewan Ave W Portage la Prairie, Manitoba R1N 4A6
Academics for today; Character for tomorrow; Jesus forever

Unified Referral and Intake System (URIS) Group B Application

In accordance with Section 15 of *The Personal Health Information Act* (PHIA), the purpose of this form is to identify the child's health care intervention(s) and 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. If you have questions about the information requested on this form, you may contact the community program.

Section I – Community program information (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	Name of community program:
	Contact person:
	Phone: Fax:
	Email:
	Address (location where service is to be delivered): Street: City/Town: POSTAL CODE:

Section II - Child information

Last Name	First Name	Birthdate
		month (print) D D Y Y Y Y
Also Known As		

Please check (✓) all health care conditions for which the child requires an intervention during attendance at the community program.

<input type="checkbox"/> Life-threatening allergy (and child is prescribed an EpiPen) Does the child bring an EpiPen to the community program? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Asthma (administration of medication by inhalation) Does the child bring asthma medication (puffer) to the community program? <input type="checkbox"/> YES <input type="checkbox"/> NO Can the child take the asthma medication (puffer) on his/her own? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Seizure disorder What type of seizure(s) does the child have? _____ Does the child require administration of rescue medication (e.g., sublingual lorazepam)? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Diabetes What type of diabetes does the child have? <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 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 sugar emergencies that require a response? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> 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"/> Bleeding Disorder (e.g., von Willebrand disease, hemophilia) What type of bleeding disorder has the child been diagnosed with? _____

<input type="checkbox"/> Steroid Dependence (e.g., congenital adrenal hyperplasia, hypopituitarism, Addison's disease) What type of steroid dependence has the child been diagnosed with? _____	
<input type="checkbox"/> Osteogenesis Imperfecta (brittle bone disease)	
<input type="checkbox"/> Gastrostomy Feeding Care 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 community program? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Ostomy Care 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	
<input type="checkbox"/> Clean Intermittent Catheterization (IMC) Does the child require assistance with IMC at the community program? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> Pre-set Oxygen 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	
<input type="checkbox"/> Suctioning (oral and/or nasal) 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	

Section III - Authorization for the Release of Medical Information

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 physician(s), 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)

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.

 Parent/Legal guardian signature

 Date

 Mailing Address

 Postal Code

 Phone number