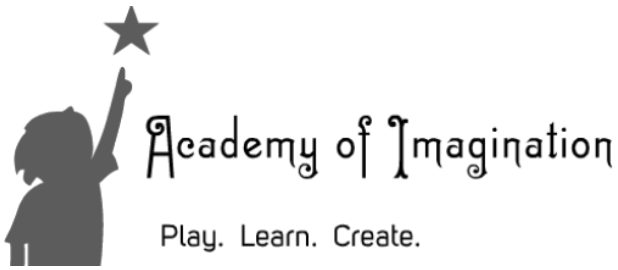

19 ave Cartier - Pointe-Claire – PQ H9S 4R5 – Tel (514) 505-1233
academie.imagination@live.com

FICHE D'INSCRIPTION / REGISTRATION FORM

September *2019 to June 2020 school year*

*Renews automatically unless otherwise specified

Date of admission: _____

Days attendance:

Monday: From: _____ to _____

Tuesday: From: _____ to _____

Wednesday: From: _____ to _____

Thursday: From: _____ to _____

Friday: From: _____ to _____

*Valid until : _____

IDENTIFICATION DE L'ENFANT / CHILD IDENTIFICATION

NOM DE FAMILLE / FAMILY NAME: _____

PRÉNOM / GIVEN NAME: _____

ADRESSE / ADDRESS: _____

DATE DE NAISSANCE / DATE OF BIRTH: A/M/J Y/M/D _____

NIREC: _____ **OR** Place of birth:_____

VILLE / CITY: _____CODE POSTAL / POSTAL CODE: _____

TÉLÉPHONE: _____AUTRE / OTHER: _____

LANGUES PARLÉ PAR L'ENFANT / LANGUAGES SPOKEN BY CHILD: _____

LANGUES COMPRIS / LANGUAGES UNDERSTOOD BY CHILD: _____

INFORMATION DES PARENTS / PARENT'S INFORMATION

MÈRE / MOTHER (Parent 1)

NOM DE FAMILLE / FAMILY NAME: _____

PRÉNOM / GIVEN NAME: _____

CELL: _____

NUMÉRO TRAVAIL / WORK PHONE: _____

COURRIEL / E-MAIL: _____

Check here if the information below is the same as child: ___

ADRESSE / ADDRESS: _____

VILLE / CITY: _____CODE POSTAL / POSTAL CODE: _____

HOME PHONE: _____

PÈRE / FATHER (Parent 2)

NOM DE FAMILLE / FAMILY NAME: _____

PRÉNOM / GIVEN NAME: _____

CELL: _____

NUMÉRO TRAVAIL / WORK PHONE: _____

COURRIEL / E-MAIL: _____

Check here if the information below is the same as child: ___

ADRESSE / ADDRESS: _____

VILLE / CITY: _____CODE POSTAL / POSTAL CODE: _____

HOME PHONE: _____

****

Please provide the Social Insurance Number (SIN) for the parent claiming the Tax Credit:

Name: _____

SIN: _____-_____-_____

PERSONNES A CONTACTER EN CAS D'URGENCES (AUTRE QUE PARENT) / AUTORISÉES A RAMASSER L'ENFANT

PERSONS TO BE NOTIFIED IN CASE OF EMERGENCY (OTHER THAN PARENTS) / AUTHORIZED TO PICK UP CHILD FROM DAYCARE

1) NOM COMPLET / FULL NAME: _____

ADRESSE / ADDRESS: _____

VILLE / CITY: _____CODE POSTAL / POSTAL CODE: _____

CELL: _____ HOME: _____

Authorized to pick up: Y / N

2) NOM COMPLET / FULL NAME: _____

ADRESSE / ADDRESS: _____

VILLE / CITY: _____CODE POSTAL / POSTAL CODE: _____

CELL: _____ HOME: _____

Authorized to pick up: Y / N

3) NOM COMPLET / FULL NAME: _____

ADRESSE / ADDRESS: _____

VILLE / CITY: _____CODE POSTAL / POSTAL CODE: _____

CELL: _____ HOME: _____

Authorized to pick up: Y / N

4) NOM COMPLET / FULL NAME: _____

ADRESSE / ADDRESS: _____

VILLE / CITY: _____CODE POSTAL / POSTAL CODE: _____

CELL: _____ HOME: _____

Authorized to pick up: Y / N

INFORMATION MÉDICALE / MEDICAL INFORMATION

NOM DU MÉDECIN / DOCTOR'S NAME: _____

TÉLÉPHONE:_____EXT:_____

ADRESSE / ADDRESS: _____

EST CE QUE L'ENFANT A DES BESOINS MÉDICAUX OU PHYSIQUES QU'ON DEVRAIT SAVOIR (EXAMPLE: PROBLÈME DE VUE, D'ÉCOUTE, INCAPACITÉ, ALLERGIE, PREND DES MÉDICAMENTS RÉGULIÈREMENT, ETC…)

❑ *OUI* ❑ *NON*

ARE THERE ANY SPECIAL MEDICAL OR PHYSICAL NEEDS THAT WE SHOULD BE AWARE OF (EXAMPLE: PROBLEMS WITH VISION, HEARING, DISABILITIES, ALLERGIES, USE OF REGULAR MEDICATIONS, ETC…)?

❑ *YES* ❑ *NO*

SI OUI EXPLIQUER / IF YES, EXPLAIN:

_____
_____
_____

Y-A-T'IL DES ALIMENTS OU LIQUIDES QUE VOTRE ENFANT NE DOIT PAS CONSOMMER? /
ARE THERE ANY FOODS OR LIQUIDS THAT YOUR CHILD SHOULD NOT HAVE?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____

Nom / Name *Signature* *Date*

19 ave Cartier - Pointe-Claire – PQ H9S 4R5– Tel (514) 505-1233

ATTESTE DE REGIE INTERNE / REGIE INTERNE ACKNOWLEDGEMENT

YES_____/ NO____ : I, the undersigned, parent or guardian of _____, attending Academy of Imagination, agree to the rules and regulations of the régie interne of the Daycare.

AUTORISATION POUR SORTIE / OUTINGS AUTHORIZATION

YES_____/ NO____ : I, the undersigned, parent or guardian of _____, attending Academy of Imagination, authorize my child to go on organized walks and outings.

AUTORISATION POUR PHOTO / PHOTO AUTHORIZATION

YES_____/ NO____ : I, the undersigned, parent or guardian of _____, attending Academy of Imagination, give permission to have my child photographed in his/her daily activities or during special events. I understand that these photos may be given to the parents of the other children, to keep for future use by the daycare, and/or for posting in and around the daycare centre or on their website/social media page.

AUTORISATION POUR AMBULANCE / AMBULANCE AUTHORIZATION

YES_____/ NO____ : I, the undersigned, parent or guardian of _____, attending Academy of Imagination, authorize my child to be transported, if needed, by ambulance to hospital.

_____ _____ _____

Nom / Name Signature Date

These authorizations are valid until the end of the contract, unless otherwise listed.

Valid until: _____

Canada Trust

Pre-authorized Transfer Service (PTS) Agreement

In this Agreement, "you" and "your" refer to you, the customer, and "we", "our" and "us" refer to The Toronto-Dominion Bank, The Canada Trust Company, TD Mortgage Corporation, and TD Pacific Mortgage Corporation, collectively and individually called "TD Canada Trust". You authorize and direct us to transfer funds as specified below, in accordance with the frequency, accounts and amounts specified. You understand that if the account does not contain funds sufficient to process the transfer, the transfer will not be processed. You acknowledge and agree that your TD Canada Trust account number will appear on the TD Canada Trust account transaction history for the account into which the funds are deposited.

Transfer from account:

Branch	Institution	Account Number	Currency	Financial Institution Name	Customer Account Name

Deposit to TD Canada Trust account:

Branch	Account Number	Currency	Amount	Frequency	Customer Account Name

Effective Start Date*: _____ End Date (if applicable): _____

New Setup ☐ Change ☐

You authorize TD Canada Trust to transfer funds as requested above. You also certify that this information is complete and correct. If funds are being transferred from a financial institution other than TD Canada Trust, you agree to accept the Terms and Conditions set out below.

_____ _____ _____

Customer signature(s)/Authorized Signing Officer(s)** Customer signature(s)/Authorized Signing Officer(s)** Date

Branch Representative: _____ **Logon ID:** _____ **Transit Number:** _____

Terms and Conditions

1. You authorize TD Canada Trust and the financial institution designated above (the "Designated Institution") to debit your account in accordance with the frequency and amounts specified, now and in the future, for the purpose of transferring funds to your TD Canada Trust account.
2. You acknowledge that this authorization is provided for the benefit of TD Canada Trust and the Designated Institution and is provided in consideration of the Designated Institution agreeing to process debits against your account in accordance with the Rules of the Canadian Payments Association.
3. You shall notify TD Canada Trust of any changes in the information concerning your accounts.
4. You may cancel this authorization at any time by contacting TD Canada Trust. Canceling this authorization does not terminate any other agreement that exists between you and TD Canada Trust. TD Canada Trust may terminate this Agreement at any time without notice.
5. You acknowledge that we reserve the right to hold funds transferred from the Designated Institution at any time in accordance with our "Hold" policy.
6. You acknowledge that delivery of this authorization to TD Canada Trust also constitutes delivery by you to the Designated Institution.
7. You represent and warrant that the account registration and signing authorities at the Designated Institution are identical to the receiving TD Canada Trust account and that all persons whose signatures are required to sign on the account at the Designated Institution have signed this Agreement.
8. Debits charged to your account at the Designated Institution pursuant to this authorization will be reimbursed, subject to written notification by you to the Designated Institution within ninety (90) days for personal accounts, and ten (10) days for non-personal accounts, of such debit that:
   (a) the debit was not made in accordance with this agreement;
   (b) this authorization was canceled by you and notice of such cancellation was given to TD Canada Trust; or
   (c) no authorization was given by you

* The Effective Start Date for other Financial Institution transfers shall be no earlier than: (i) the second business day after the date of execution of this Agreement, if the Agreement is signed in branch or returned to us by facsimile transmission, or (ii) the fourteenth day after the date of execution of this Agreement, if the Agreement is signed and returned to us by ordinary pre-paid post. No transfer shall be processed until such time as we are in receipt of a signed Agreement.

** If you are a non-personal customer, signatures on this Agreement must conform with the signing authorities on file with us.

591690 (0105)

Academy of Imagination

Play. Learn. Create.

Fee Schedule 2019/2020

2019	Days:	Fees:	2020: Days:	Fees:
January	23	$1035.00	23	$1035.00
February	20	$900.00	20	$900.00
March	21	$945.00	22	$990.00
April	22	$990.00	22	$990.00
May	23	$1035.00	21	$945.00
June	20	$900.00	22	$990.00
July	23	$1035.00	23	$1035.00
August	22	$990.00	21	$945.00
September	21	$945.00	22	$990.00
October	23	$1035.00	22	$990.00
November	21	$945.00	21	$945.00
December	22	$990.00	23	$1035.00
Totals:	**152**	**$11745.00**	**262**	**$11790.00**
PTS payment:		**$978.75**		**$982.50**

Payment options:

_____ Post Dated cheques for the year - dated for the 1st or the 15th OR Split between the 1st and 15th

_____ Pre-Authorised Transfer (PTS) - PTS payments end in December and new forms will be filled out for each January to confirm continued enrolment. Should you start mid year, your total will be adjusted to reflect the actual number of days attended. The fee may be lower or higher depending on how many days of care left in the year, divided by the amount of months left in the year.