



John Taylor Collegiate

470 Hamilton Avenue Winnipeg, Manitoba R2Y 0H4
Phone (204) 888-8930 Fax (204) 889-9999

Date Received: _____

MET#: _____
Advisor: _____
Catchment: _____

STUDENT REGISTRATION 2010-2011

Grade: **9 10 11 12**

(circle one)

Legal Name: _____ **Gender:** F ___ M ___
(Last) (First) (Middle) **Birthdate (m/d/y):** ___/___/___

Mailing Address: _____ / _____ / _____
Apt#/Street Address City Postal Code

Phone Number: _____ **Current Grade:** _____

Family Information

Student resides with: Mother & Father Mother only Father only Guardian(Specify) _____
Name of person(s) who has (have) legal custody: _____

Father's Information Name: _____ Home phone: _____
Address: _____

Name of Employer: _____ Work Phone: _____ Ext. _____
Email Address: _____ Cell: _____

Mother's Information Name: _____ Home phone: _____
Address: _____

Name of Employer: _____ Work Phone: _____ Ext. _____
Email Address: _____ Cell: _____

Guardian's Information Name: _____ Home phone: _____
Address: _____

Name of Employer: _____ Work Phone: _____ Ext. _____
Email Address: _____ Cell: _____

Choose One: ___ Returning to John Taylor ___ New to John Taylor
Name of current school or last school attended _____ Address _____
If current school is not in St. James-Assiniboia, have you ever attended school in St. James-Assiniboia ___ No ___ Yes
If Yes, name of school: _____

Medical Information: (Please update information)

Emergency Contact: (In event parents cannot be reached)
Name: _____ Phone: _____
Relationship to Student: _____

Doctor Information: Name: _____ Phone: _____

It is important that we are aware of any medical conditions or on-going prescribed medications.

Diagnosed Health Needs – Please check all that apply:

Is the student on any on-going prescribed medications: ___ Yes ___ No

If yes, who administers the medication during school hours:

___ Home ___ School ___ Self-administered

___ Allergies (EpiPen: ___ Yes ___ No) ___ Asthma (Inhaler: ___ Yes ___ No)

___ Diabetes ___ Seizures ___

Other-please specify: _____

Medical Information 9 Digit Health No. _____/_____/_____ 6 Digit Health No. _____
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