CONTINUING EDUCATION 2019
SUMMER REGISTRATION

We reserve the right to limit the size and number of classes. If the class you have registered for is full or cancelled you will be contacted by email or telephone and offered the choice of registering in another course.
Applications will NOT be accepted without this form being completed in full. This includes a copy of proof of address & citizenship. Fees must be paid in full at time of registration.

_____ _____ _____
LEGAL LAST NAME USUAL LAST NAME (if different from legal) MIDDLE NAME

_____ _____ _____
LEGAL FIRST NAME USUAL FIRST NAME (if different from legal) STUDENT EMAIL ADDRESS

_____ Date of birth _____ ☐ Male ☐ Female
Previous Last Name if Applicable (ie, maiden name) (dd/mm/yyyy)

Student # _____ Personal Education Number (P.E.N. #) _____

Current Address _____
City Prov Postal Code

Phone _____ Place of Birth_____ International Student? Yes_____ No_____

Did you graduate high school in any City, Province, or Country? Yes___ No___ If yes, what year did you grad? _____

What is the name & the location of the last high school you attended? _____

July 2 – 25, 2019 **Credit Grade 10 – 12**	**Course Request**	**Office use Section #**	**Principal's Signature**
8:00 am - 1:30 pm			

OFFICE USE ONLY

☐ **Canadian Citizenship verified:**	☐ **Landed Immigrant verified:**	☐ Non-Graduate	Registration Form Verified
☐ Canadian Birth Cert. ☐ Canadian Passport ☐ Status Card ☐ Proof of Address	☐ Canadian Citizenship Card ☐ Signed Record of Landing ☐ Perm. Res. Card ☐ Proof of Address ☐ **International Student**	☐ Over 19 years ☐ Under 19 years ☐ Graduate ☐ Over 19 years ☐ Under 19 years	_____ Initial

Method of Payment: ☐ **Cheque** ☐ **Cash**

Graduated Adult : $500 _____ **Adult Non Grad $20** _____ **School Age Grad $20** _____

Amount Received: **$**_____ **RECEIPT #:**_____ **Initial** _____

Date: _____ **Time:** _____

Revised July 2019

MEDICAL INFORMATION:

Care Card Number: _____ _____ _____

Emergency Contact(s): _____ daytime phone_____

_____ daytime phone_____

Please specify any health conditions and/or medications required for treatment:_____

Parent / Guardian / Homestay Parent / Host Family RESIDING with the student
(*to be completed for STUDENTS under the age of 19)*

Last Name	First Name	Relationship to student:
Cell phone: Home Phone:	Work phone:	Parent Email:
Last Name:	First Name:	Relationship to student:
Cell phone: Home Phone:	Work phone:	Parent Email:

I hereby certify the information contained on this form is accurate. I also understand that once the course has started, there are NO refunds and if I do choose to withdraw a final mark of an "F" will be given.

Signature _____ **Date:** _____

The personal information collected on this form is required for the operation of the Continuing Education Program of School District No. 61.
It is subject to the Freedom of Information and Protection of Privacy Act and will be kept secure and confidential according to the Act.