1119 Lazard Avenue
Ottawa, Ontario K2C 2R5
Telephone:(613) 274-0110
Email: office@torahday.ca
Website: www.torahday.ca

Torah Day School of Ottawa

Application for Admission

Office Use Only	Age Verification
-	

STUDENT

Name (Legal)_________________________________ _________________________________ Gender: **M** ☐ **F** ☐
Surname First Name(s)

_________________________________ Date of Birth _______________ Hebrew Birthday_______________
Name Used Year / Month / Day

Address ____ _________________________________
Street Name and Number City and Postal Code

Student's Country of Origin (i.e. country where born):

Telephone _____________________________ Student's Citizenship____

Student Lives with ___________________________________ Legal Guardian___________________________________

Age of Student on December 31, of this year _____________ Grade Entering as of September of this year _______

PARENT/GUARDIAN (with whom the student lives)

____ ____ Title ______________
Surname First Name(s) (i.e. Miss, Mr.. Mrs.)

Occupation:____

Business Telephone______________________________ Ext _______________ Cell Phone _________________________

Email Address ____ Citizenship ___________________________

SECOND PARENT/GUARDIAN

____ ____ Title ______________
Surname First Name(s) (i.e. Miss, Mr.. Mrs.)

Occupation:____

Business Telephone______________________________ Ext _______________ Cell Phone _________________________

Email Address ____ Citizenship ___________________________

Complete this section only if different from student

Address ____ ____
Street Name and Number City and Postal Code

Home Telephone ______________________________

Grandparent Information

Child's Maternal Grandparents (If living)	Child's Paternal Grandparents (If Living)
Street Address	Street Address
City / State/Prov. / Postal Code/Zip	City / State/Prov. / Postal Code/Zip
Telephone & Email	Telephone & Email

CUSTODY ARRANGEMENTS (if applicable)

Please inform the office regarding any court orders or any formal agreements that affect custody arrangements (i.e. non-custodial parent picks up child alternate weekends, No Contact Orders, etc.)

____

____

____

Torah Day School of Ottawa requires a copy of legal agreements concerning no-contact orders or special living arrangements.

HEBREW INFORMATION

Is Mother Jewish from Birth? ☐ Yes ☐ No If No, Date of Conversion______________________________

Is Father Jewish from Birth? ☐ Yes ☐ No If No, Date of Conversion______________________________

Is the Child Jewish from Birth? ☐ Yes ☐ No If No, Date of Conversion______________________________

Is the Child Adopted? ☐ Yes ☐ No Child's Hebrew Name______________________________

If applicable, please attach copies of all conversion certificates.

MEDICAL INFORMATION

____
Student Health Card Number

Doctor's Name______________________________ ______________ ______________________
Surname Initial Telephone

Emergency Contact______________________________ ______________ ______________________
Surname First Name Telephone

Please attach a copy of immunization records.

Please complete any other relevant medical information

____

____

Medical Interventions: (i.e. Occupational Therapy, Speech Therapy, Counselling, etc.)

____

____

PREVIOUS SCHOOL INFORMATION (if applicable)

Name____

Address ____

Telephone number for school records__________________________________ Contact Person _______________

Last Year Attended ____________________ Current Grade Level ________________

Please provide a copy of your child's last report card.

Has your child ever been held back or moved ahead a grade? ☐ Yes ☐ No If yes, please explain _________________

____

____

Has your child ever received Special Education or Resource Assistance? ☐ Yes ☐ No

If yes, please provide dates, locations and areas of Special Education:

____

____

Has your child ever/does your child currently have an IEP or similar learning plan? If YES please provide a copy.

Has your child had serious behavioural issues at school; such as those resulting in suspension or dismissal? ☐ Yes ☐ No
If yes, please provide additional information:

____

____

Has your child received any educational or medical testing relating to school? ☐ Yes ☐ No
If yes, please provide additional information:

____

____

Does your child take any regular medications? ☐ Yes ☐ No

If yes, please specify medication type and dosage:

____

____

OTHER CHILDREN IN THE FAMILY

Surname	First Name	Gender M/F	Birth Date (Yr./Month)	School (if applicable)
____________________________	__________________	☐	____________	________________________
____________________________	__________________	☐	____________	________________________
____________________________	__________________	☐	____________	________________________
____________________________	__________________	☐	____________	________________________
____________________________	__________________	☐	____________	________________________
____________________________	__________________	☐	____________	________________________
____________________________	__________________	☐	____________	________________________
____________________________	__________________	☐	____________	________________________
____________________________	__________________	☐	____________	________________________
____________________________	__________________	☐	____________	________________________

ACKNOWLEDGEMENT:

The personal information on this form is gathered under the authority of the Education Act and will be used by the school and central administrative staff to provide a broad range of academic, health and administrative services. Anyone having the right may access this information by contacting the principal of the school. Please keep the school advised of any changes in the above information as soon as possible.
Confidential When Completed.

____ ______________________________________

Parent/Guardian Signature Date

SCHOOL ENTRY IMMUNIZATION & TUBERCULOSIS ASSESSMENT

Date Form Completed : ____-___-___ (Year / Month / Day)

STUDENT INFORMATION: (Please print clearly and complete ALL sections of the form)

Family Name ______ Given Name ______ Sex ___ Date of Birth (Year-Month-Day) ____-___-___

Ontario Health Card Number ____-____-____ Name of School ______ Grade ___

Student's Physician's Name ______ Physician's Telephone ___-___-____

Previous School, Nursery or Daycare attended in Ottawa ______

Has the student lived or travelled outside of Canada or in a First Nations, Inuit or Métis community in Canada for 3 months or longer during the last 5 years?

☐ No ☐ Yes - (call 613-580-6744 extension 24108. Certification is required for school entry.)

Name of Countries Lived in During Last 5 Years ______ Date of Arrival in Canada (y/m/d) ___-___-___

Name of First Nations Community ______

PLEASE ATTACH A PHOTOCOPY OF THE STUDENT'S IMMUNIZATION RECORD TO THIS FORM. THESE REQUIREMENTS APPLY TO ALL SCHOOLS, INCLUDING PRIVATE SCHOOLS.

PARENT/GUARDIAN INFORMATION: (Please print clearly)

Last Name ______ First Name ______ Relation To Child ______

Home Address ______ Apt/Unit ____ City ______ P.C. ___-___

Tel (home) ___-___-____ Tel (work) Mother ___-___-____ ext. ____ Tel (work) Father ___-___-____ ext. ____

Office Use Only

Pentacel ☐ Quadracel ☐

MMR #1 ☐ MMR #2 ☐

Polio ☐ Td Polio ☐

TST ☐ Adacel ☐

Assessor/Centre: ______

Date assessed (y/m/d) ______

by ______

Date Input (y/m/d) ______

by ______

Date certified (y/m/d) ______ Y.F. ☐

by ______

When your child receives any vaccination or if you have any questions contact the

Ottawa Public Health - Immunization Program

100 Constellation Crescent, 7th Floor West Ottawa, ON K2G 6J8

Tel: 613-580-6744 extension 24108 Fax: 613-580-9660 Email: Immunization@ottawa.ca

Personal health information is collected on this form pursuant to section 11 of the Immunization of School Pupils Act, R.S.O. 1990, c. I.1, ("ISPA"). The parent of a pupil has an obligation to cause the pupil to complete the program of immunization, as indicated in section 3 of ISPA and section 5 of the Regulation 645 of the ISPA. Your personal health information collected on this form will be shared on a confidential basis with the City of Ottawa Public Health Branch. Questions regarding this collection may be addressed to: Supervisor, Immunization Program, City of Ottawa Public Health Branch, 100 Constellation Cr., Ottawa, ON K2G 6J8 tel: 613-580-6744 ext.24108 e-mail: Immunization@ottawa.ca.

Personal health information is collected on this form according to the Mandatory Health Programs and Services Guidelines published pursuant to section 7 of the Health Protection and Promotion Act, R.S.O. 1990, c. H.7. Your personal health information will be used to promote the screening of all persons in a high-risk group for tuberculosis and to asses those testing positive. Your personal health information may be shared on a confidential basis with the City of Ottawa Public Health Branch. Questions regarding the collection of personal health information may be addressed to: Supervisor, Immunization Program, City of Ottawa Public Health Branch, 100 Constellation Cr., Ottawa, ON K2G 6J8 tel: 613-580-6744 ext. 24108, e-mail: Immunization@ottawa.ca.