**Aboriginal Head Start Program**

**Delegation of Power and Duty**

Consent to ordinary medical and dental care:

This authority includes treatment for minor illnesses, injuries, and other procedures that are performed routinely and do not require hospitalization.

The RIEL Institute Aboriginal Head Start Program staff have the authority to admit this child to hospital, but not to authorize any treatment or tests except according to the following clause:

Consent to emergency treatment or surgical procedures. This authority includes immediate measures necessary to preserve the child’s life, health, and physical well-being. The authority must be used only if contacting the primary or secondary caregiver will delay treatment enough to endanger the child’s life. After authorizing treatment, the staff must immediately notify the caregivers.

**Delegation of Power in Case of Emergency**

|  |  |
| --- | --- |
| Child’s Legal Name: |  |

(first) (middle) (last)

|  |  |
| --- | --- |
| Child’s Date of Birth: |  |

(month/day/year)

|  |  |
| --- | --- |
| Band/First Nation: |  |

|  |  |
| --- | --- |
| Status Number: |  |

|  |  |
| --- | --- |
| Alberta Health Care Number: |  |

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, delegate the Power and Duty set out above this delegation to the staff of the RIEL Institute Aboriginal Head Start Program regarding this child.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Caregiver Signature |  | Date |
| Witness Signature |  | Date |

**Aboriginal Head Start Program**

**Transportation Procedures**

The RIEL Institute Aboriginal Head Start Program has two 16 passenger school buses. These buses are used to transport those children who are registered in this program and who live within the designated boundaries set forth by the RIEL Institute Aboriginal Head Start Program.

|  |  |  |
| --- | --- | --- |
| Hours for Pick-up | 7:30 am to 8:15 am | 11:30 am to 12:45 pm |
| Hours for Drop-off | 11:30 am to 12:30 pm | 4:00 pm to 5:00 pm |

The bus will pick-up/drop-off your child at home or at the designated daycare facility.

Caregivers are required to bring the child to the bus upon pick-up and meet the bus upon drop-off.

At pick-up time the bus will stop at each home for exactly 3 minutes. Please ensure your child is dressed and ready for the bus. If your child is not ready to go, and there is no signal to the bus driver to wait, he/she will carry on with the route and there will be no reattempt to pick-up your child.

At drop-off time if you are not there to meet your child, an attempt will be made to contact you and the secondary caregiver (if available). If there is no contact, the driver will continue the route and attempt to drop-off the child at the end of the route. If there is still no one to meet the child a second attempt to contact you will be made. At this time the driver will attempt to contact the emergency phone numbers. If there is still no contact at this time, the driver will contact the Children’s Crisis Line.

A transportation permission form must be signed for all children who ride the bus.

If a caregiver has an alternate person meeting their child at drop-off time, the bus drivers and home liaison must be informed verbally and in writing prior to the child being dropped off. Alternate caregivers will be required to show proper identification to driver before the child is released to them.

If your child will not be riding the bus on any given day, the bus driver must be notified the night before, or at least 30 minutes before he/she is scheduled to arrive at your residence.

Caregivers and Emergency contacts are required to read, agree, and abide by these procedures.

|  |  |  |
| --- | --- | --- |
| Caregiver Name |  | Witness Name |
| Caregiver Signature |  | Witness Signature |
| Date |  | Date |

**Aboriginal Head Start Program**

**Transportation Permission**

|  |  |
| --- | --- |
| Child’s Legal Name: |  |

(first) (middle) (last)

|  |  |
| --- | --- |
| Child’s Date of Birth: |  |

(month/day/year)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby give consent for my child to be transported by the RIEL Institute Aboriginal Head Start Program to and from school each day.

I understand that every necessary precaution will be taken to ensure students’ safety. Beyond this, I agree to hold RIEL Institute Aboriginal Head Start Program harmless in the event of any injury to my child while he/she is being transported to and from school.

|  |  |  |
| --- | --- | --- |
| Caregiver Name |  | Witness Name |
| Caregiver Signature |  | Witness Signature |
| Date |  | Date |

**Aboriginal Head Start Program**

**Field Trip Permission Form**

|  |  |
| --- | --- |
| Child’s Legal Name: |  |

(first) (middle) (last)

|  |  |
| --- | --- |
| Child’s Date of Birth: |  |

(month/day/year)

The following is a Blanket Permission Form which will allow your child to attend and be transported by the RIEL Institute Aboriginal Head Start Program to any and all field trips in and around the Calgary city limits. Regularly scheduled field trips and activities will be listed on your child’s monthly classroom calendar that is distributed at the beginning of each month.

I understand the above and hereby give permission for my child to attend any and all planned field trips and activities during the school year.

I hereby give permission for my child to be transported by the RIEL Institute Aboriginal Head Start Program buses to and from any and all field trips and activities during the school year.

I authorize RIEL Institute Head Start Staff to obtain emergency medical treatment for my child in cases of emergency.

I also understand that I will not hold the RIEL Institute Aboriginal Head Start Program liable for any injury to my child during any and all of the planned field trips and activities.

|  |  |  |
| --- | --- | --- |
| Caregiver Name |  | Witness Name |
| Caregiver Signature |  | Witness Signature |
| Date |  | Date |

**Aboriginal Head Start Program**

**Audio/Visual Recording Consent**

|  |  |
| --- | --- |
| Child’s Legal Name: |  |

(first) (middle) (last)

|  |  |
| --- | --- |
| Child’s Date of Birth: |  |

(month/day/year)

I hereby acknowledge that the RIEL Institute Aboriginal Head Start Program may use, reproduce, or distribute any photographs, slides, video or other similar material associated with the program and related events or activities for promotional and archival purposes.

I understand that this consent shall be in effect indefinitely, however, I may revoke my consent at any time by giving written consent to the program coordinator or home liaison of the RIEL Institute Aboriginal Head Start Program.

All audio and visual recordings will be stored securely at the RIEL Institute for Education and Learning head office.

|  |  |  |
| --- | --- | --- |
| Caregiver Name |  | Witness Name |
| Caregiver Signature |  | Witness Signature |
| Date |  | Date |

**Aboriginal Head Start Program**

**Caregiver Participation Agreement**

|  |  |
| --- | --- |
| Child’s Legal Name: |  |

(first) (middle) (last)

Caregiver participation plays a crucial role in the success of the RIEL Institute Aboriginal Head Start Program. Your participation as a caregiver will benefit the program as well as yourself and your child. The caregiver portion of the program requires you to become involved. We attempt to be flexible in order to accommodate each caregiver’s personal availability.

I do agree to fulfill my caregiver obligation to the RIEL Institute Aboriginal Head Start Program. I understand that my participation in the program will benefit my child and myself as a caregiver.

I will attend caregiver gatherings and functions.

I will ensure my child attends the program on a regular basis.

I will contact the bus driver when my child will not be riding the bus.

I will contact the teacher when my child will not be attending class.

I will permit home visits by the RIEL Institute Aboriginal Head Start staff regarding my child and to access community resources.

I will volunteer a minimum of 9 hours of my time to the program.

I am willing to contribute to the program by sharing my skills, talents, and knowledge.

Volunteering will include, but not be limited to:

|  |  |
| --- | --- |
| Classroom Participation | Cooking Traditional Foods |
| Fieldtrip Attendance | Drumming |
| Material Preparation | Singing |
| Making Playdoh | Crafts |

|  |  |  |
| --- | --- | --- |
| Caregiver Name |  | Witness Name |
| Caregiver Signature |  | Witness Signature |
| Date |  | Date |

**Aboriginal Head Start Program**

**Health Promotion and Assessment Permission Form**

|  |  |
| --- | --- |
| Child’s Legal Name: |  |

(first) (middle) (last)

|  |  |
| --- | --- |
| Child’s Date of Birth: |  |

(month/day/year)

I hereby authorize various agencies to observe my child in the RIEL Institute Aboriginal Head Start program and provide necessary documentation and consultation regarding my child in order to enhance my child’s learning in the classroom.

I understand that as part of the services provided by the RIEL Institute Aboriginal Head Start Program the following services and screenings may be completed with and/or provided for my child.

* Measurement of height and weight
* Dental screening
* Hearing screening
* Vision screening
* Brigance Inventory of Early Childhood Development II (IED-II)
* Safe Preschoolers Education & Awareness Kit (S.P.E.A.K)
* Language and Speech referral/assessment/therapy (if required)
* Occupational Therapist referral/assessment/therapy (if required)
* Physical Therapist referral/assessment/therapy (if required)

I hereby give permission for the information collected to be used by the RIEL Institute Aboriginal Head Start Program and the above agencies for research and statistical purposes. I understand that the information will be coded in such a way that the identities of individual children and parents will be kept confidential for research and statistical purposes.

|  |  |  |
| --- | --- | --- |
| Caregiver Name |  | Witness Name |
| Caregiver Signature |  | Witness Signature |
| Date |  | Date |

**Aboriginal Head Start Program**

**Release of Information**

|  |  |
| --- | --- |
| Child’s Legal Name: |  |

(first) (middle) (last)

|  |  |
| --- | --- |
| Child’s Date of Birth: |  |

(month/day/year)

I hereby authorize the staff of the RIEL Institute Aboriginal Head Start Program to release information and assessment reports that may be useful to my child’s ongoing education and to assist in receiving further resources and programming.

|  |  |  |
| --- | --- | --- |
| Caregiver Name |  | Witness Name |
| Caregiver Signature |  | Witness Signature |
| Date |  | Date |