



# OVERNIGHT CAMP AND RESPITES

## REGISTRATION FORM

PARTICIPANT						
First name				Last name		
Date of birth				Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Lives with	<input type="checkbox"/> Main contact <input type="checkbox"/> Secondary contact <input type="checkbox"/> Other :					
SUMMARY HEALTH FORM						
Health ins. No. (RAMQ)				Expiry date		
Hearing impairment	<input type="checkbox"/> Signs (gestural) <input type="checkbox"/> Oralist		Language disability	<input type="checkbox"/> Dysphasia <input type="checkbox"/> Other :		
Intellectual deficiency	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			<input type="checkbox"/> ASD		
Multiple deficiencies	<input type="checkbox"/> Shadowing 1:1 <input type="checkbox"/> Shadowing 1:2		Other deficiency :			
Swimming level	<input type="checkbox"/> None <input type="checkbox"/> Average <input type="checkbox"/> Good		T-Shirt kids	<input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large <input type="checkbox"/> X-Large		
			T-Shirt adult	<input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large <input type="checkbox"/> X-Large		
PARENTS. LEGAL GUARDIANS OR FOSTER FAMILY						
<b>Principal respondent</b> (First / last name)						
Address						
City		Province		Postal code		
Home phone		Mobile :		Work :		
Relationship with participant :			Email			
<b>Secondary respondent</b> (First /last name)						
Address						
City		Province		Postal code		
Home phone		Mobile :		Work :		
Relationship with participant :			Email			
Tax receipts in name of :			S.I.N.		S.I.N. mandatory for tax receipts	
OTHER CONTACT IN CASE OF EMERGENCY (Mandatory)						
Name Contact 1:		Phone :		Relationship with participant :		
Name Contact 2 :		Phone :		Relationship with participant :		
Social worker:		Telephone and email :				
<b>How did you hear about the Centre ?</b> <input type="checkbox"/> Reference <input type="checkbox"/> ACQ <input type="checkbox"/> Web site <input type="checkbox"/> Advertising <input type="checkbox"/> School <input type="checkbox"/> Other :						



À L'ÉTAT *naturel*

2464, boul. Perrot, Notre-Dame-de-l'Île-Perrot, QC J7V 8P4 info@mon-camp.ca T 514 453-7600

MON-CAMP.CA



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### AUTHORIZATIONS

I authorize the person responsible to make appropriate decisions pertaining to the health and safety of the participant. I hereby authorize the management of the Center to act on my behalf in case of emergency in order to administer first aid or other medical and/or surgical care required by the state of health of the participant.

Yes  No

I authorize the Centre Notre-Dame-de-Fatima to administer all types of non-prescription medication (over the counter medication), such as Acetaminophen (Tylenol) – Anti-emetic (Gravol) – Antibiotic cream (Polysporin) – Other (cough syrup ...).

Yes  No

I authorize the Center to use photographs, and interviews of the participant for distribution in the organization's brochures, on television or other media.

Yes  No

The Center does not assume responsibility for lost personal effects or medical expenses. In case of emergency transportation to a health facility, all fees will be incurred by the parents.

I hereby confirm the registration of \_\_\_\_\_ .I accept the terms of payment and refund policy as they appear on the registration form and on the Center's website.

Signature : \_\_\_\_\_ Date : \_\_\_\_\_

**I WISH TO APPLY FOR FINANCIAL ASSISTANCE FOR THIS PARTICIPANT**

Please append the completed form along with your "Notice of Assessment". We will contact you to validate your eligibility.

**★★ PLEASE INCLUDE THE FOLLOWING WITH YOUR REGISTRATION FORM ★★**

Photo  Health form  Terms of payment  Authorizations

*These forms will be valid for two years (except for financial assistance 1 year)*

★★★★★



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