



CAMP DE VACANCES ET RÉPITS

REGISTRATION FORM

PARTICIPANT					
First name		Last			
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 number		Expiration			
Hearing	<input type="checkbox"/> Signs	<input type="checkbox"/> Oralist	Language disability	<input type="checkbox"/> Dysphasia	<input type="checkbox"/> Other :
Intellectual	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> ASD	
Multiple	<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 child	<input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large <input type="checkbox"/> X-Large
			T-Shirt adu	<input type="checkbox"/> Small	<input type="checkbox"/> Medium <input type="checkbox"/> Large <input type="checkbox"/> XL <input type="checkbox"/> 2XL
PARENTS, LEGAL GUARDIANS OR FOSTER FAMILY					
Main contact (First and last)					
Address					
City		Province		Postal	
Home phone		Mobile :		Work :	
Relationship with participant :					
Secondary contact (First					
Address					
City		Provin		Postal	
Home phone		Mobile :		Work :	
Relationship with participant :		Email			
Name on tax receipts		S.I.N.	S.I.N. mandatory for tax receipts		
OTHER CONTACT IN CASE OF EMERGENCY (Mandatory)					
Name Contact 1 :		Telephone :	Relation w/participant :		
Name Contact 2 :		Telephone :	Relation w/participant :		
Social worker :		Telephone and email :			
How did you hear about the Centre ? <input type="checkbox"/> Reference <input type="checkbox"/> ACQ <input type="checkbox"/> Web site <input type="checkbox"/> School <input type="checkbox"/> CSSS <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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I authorize the person responsible to make appropriate decisions pertaining to the health and safety of the participant. I therefore authorize the management to act in my name in case of emergency in order to administer first aid or other medical or surgical help related to 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 sale), such as Acetaminophen (Tylenol) – Dimenhydrinate (Gravol) – Cream form of antibiotics (Polysporin) – Other (cough syrup ...).

Yes No

I authorize the Center to use photographs, and interviews of the participant for use in publishing in our brochures, on television or other media.

Yes No

The Center does not take responsibility for lost personal effect 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.

I WISH TO APPLY FOR FINANCIAL AID FOR THIS PARTICIPANT

Please send the completed form and copy of your "Avis de cotisation". We will contact you to confirm your eligibility.

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

Photo Health form Terms of payment

These forms will be valid for two years

★★★★★



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