



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 ins. number			Exp.		
Hearing	<input type="checkbox"/> Signs <input type="checkbox"/>	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		
Ratio	<input type="checkbox"/> Group 1:4 <input type="checkbox"/> Shadowing 1:1 / 1:2		Other deficiency :		
Swimming level	<input type="checkbox"/> None <input type="checkbox"/> Average <input type="checkbox"/>		T-Shirt child	<input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large <input type="checkbox"/> X-Large	
Password for departure			T-Shirt adult	<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					
Name Main contact					
Address					
City		Province		Postal	
Home phone		Mobile :			
Relationship with participant :		Email :			
Name Secondary contact					
Address					
City		Provin		Postal	
Home phone		Mobile :		Work :	
Relationship with participant :		Email			
Name on tax receipts		S.I.N.		mandatory tax receipts	
OTHER CONTACT IN CASE OF EMERGENCY (Mandatory)					
Name Contact 1:		Tel :		Relation :	
Name Contact 2 :		Tel :		Relation :	
Social worker :		Tel & 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 :					



2464, boul. Perrot, Notre-Dame-de-L'Île-Perrot, Québec J7W 2Y9 - info@mon-camp.ca 514.453.7600

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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

These forms will be valid for two years

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