



# OVERNIGHT CAMP AND RESPITES

## REGISTRATION FORM

PARTICIPANT			
First name		Last	
Date of birth		Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> N/A
Lives with	<input type="checkbox"/> Main contact <input type="checkbox"/> Secondary contact <input type="checkbox"/> Other :		
SUMMARY HEALTH FORM			
Health insurance #		Expiry date	
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"/> Shadow 1:1 <input type="checkbox"/> 1:2 <input type="checkbox"/> Group		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"/> XL
	T-Shirt Adults	<input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large <input type="checkbox"/> XL <input type="checkbox"/> XXL	
PARENTS / LEGAL GUARDIANS OR FOSTER FAMILY			
<b>Principal respondent</b> (First / last name)			
Address			
City		Province	Postal code
Home phone		Mobile or work :	
Relationship with participant :		Email	
<b>Secondary respondent</b> (First /last name)			
Address			
City		Province	Postal code
Home phone		Mobile or work :	
Relationship with participant :		Email	
Tax receipts in name of :		S.I.N.mandatory	
OTHER CONTACT IN CASE OF EMERGENCY (Mandatory)			
Name Contact 1:	Phone :	Relationship	
Name Contact 2 :	Phone :	Relationship	
Social worker :	phone / 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, Québec J7W 2Y9 - 514.453.7600 - [info@mon-camp.ca](mailto:info@mon-camp.ca)  
**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

*These forms will be valid for two years*

Send by email at [inscription@mon-camp.ca](mailto:inscription@mon-camp.ca)

★★★★★



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