LEISURE ACTIVITIES
Fall 2019

Registration Form

IMPORTANT:

PLEASE ATTACH A RECENT PHOTOGRAPH HERE

REQUIRED FOR ID

Participant Profile

Name of the activity: _____

Participant's name: _____

Date of birth: _____ /____ /_____ Age: _____
D M YEAR

Height: _____ Weight: _____ Eye color: _____ Hair color: _____

Language(s) used: _____ Verbal: ☐ Non-verbal: ☐

Receiving services from: Miriam H&S ☐ CROM ☐ Other ☐ (please specify) _____

Name of educator/social worker: _____Tel no.: _____

Type of residential setting: Private Home or Apt. ☐ R.C. ☐ R.I. ☐ R.T.F. ☐

Permanent address: _____

Primary phone number (for animators' use): _____ Secondary phone: _____

Email: _____

Emergency contact person: _____ Tel. no.: _____

Diagnosis: _____

IMPORTANT: Tell us about the participant/yourself – likes and dislikes, any pertinent information our animators should know regarding personality, behavior, distinguishing physical, emotional, mental and intellectual traits, etc. Please, attach behaviour plan if applicable.

_____

_____

_____

_____

Transportation Abilities:

Able to use public transit independently? Yes ☐ No ☐

Familiar bus routes/frequented areas: _____

Street safety skills? Yes ☐ No ☐ Comment: _____

Transport Adapté FILE NUMBER: (if applicable) _____

Medical Information:

Medicare no.: _____ Expiry Date: _____

Health problems (specify)

- Cardiac Problems ☐
- Diabetes ☐
- Asthma ☐
- Coagulation Problems ☐
- Epilepsy ☐
  Triggers: _____
  Procedures: _____
- Other: _____
- Allergies: _____ Epi-Pen: Yes ☐ No ☐

ATTACH A LIST OF ALL MEDICATIONS USED (during or outside of program hours): PRN, MEDICATION SOLD OVER THE COUNTER, VITAMINS, ETC.

Medication taken during program hours must be listed separately, below, and sent in a clearly labelled dosette box. We must have written notification of any medication changes when they occur:

Medication: _____ dosage: _____ time given: _____

Medication: _____ dosage: _____ time given: _____

Pharmacy: _____ Tel. No.: _____

Name of treating physician: _____ Tel. No.: _____

Consent to Release of Photos:
I, the undersigned, authorize the Gold Centre/Miriam Foundation to use photographs/digital images of the participant taken during activities for promotional purposes such as letters to Foundation donors: Yes ☐ No ☐
Signature: _____ Date: _____
(*Please sign and indicate relationship to participant, i.e.,: parent, tutor, guardian, etc.*)

Form completed by _____ Tel. No.: _____

Payment Information

Payment amount: $_____
○ Cheque (payable to Gold Centre) ○ Cash

OFFICE USE ONLY: Rec'd ____ /____ Pymt _____