

**PARTICIPANT INFORMATION**

Participant name: \_\_\_\_\_

Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_      Age: \_\_\_\_\_

Height: \_\_\_\_\_      Weight: \_\_\_\_\_      Eye color: \_\_\_\_\_

Hair color: \_\_\_\_\_

Language(s) used: \_\_\_\_\_  Verbal  Non-verbal

Receiving services from:

 Miriam H&S       CROM       Other (specify) \_\_\_\_\_

Name of educator/social worker: \_\_\_\_\_

Type of residence:

 Private home or apt       R.C.       R.T.F

Permanent Address: \_\_\_\_\_

Primary Phone (for animators' use): \_\_\_\_\_ Relation to participant: \_\_\_\_\_

Secondary Phone: \_\_\_\_\_ Relation to participant: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency contact name : \_\_\_\_\_ Phone: \_\_\_\_\_

**PARTICIPANT PROFILE****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.

General: \_\_\_\_\_

\_\_\_\_\_

Behaviours: \_\_\_\_\_

\_\_\_\_\_

Strategies: \_\_\_\_\_

\_\_\_\_\_

**IMPORTANT:**Please attach a  
RECENT photo  
here**Required for ID**

Interests: \_\_\_\_\_  
\_\_\_\_\_

## TRANSPORTATION ABILITIES

Able to use public transit independently?  YES  NO

Familiar bus routes/frequented areas: \_\_\_\_\_

Street safety skills?  YES  NO Comment: \_\_\_\_\_

Participant uses:  walker;  wheelchair;  other: \_\_\_\_\_;  not applicable

Transport Adapté File Number (if applicable): \_\_\_\_\_

## MEDICAL INFORMATION

Medicare number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Health problems (specify):

Cardiac  Diabetes  Asthma  Coagulation  not applicable

Epilepsy

○ Triggers : \_\_\_\_\_

○ Procedures : \_\_\_\_\_

Other \_\_\_\_\_

Allergies \_\_\_\_\_

Epi-Pen :  YES  NO

**MEDICATIONS:** Please list all medication taken during or outside of program hours, including PRN, MEDICATION SOLD OVER THE COUNTER, VITAMINS, ETC. We must have written notification of any medication changes when they occur:

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Time given: \_\_\_\_\_

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Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

Treating physician: \_\_\_\_\_ Phone: \_\_\_\_\_

## PHOTOS CONSENT

I, the undersigned, authorize the Miriam Foundation to use photographs/digital images of the participant taken during activities for promotional purposes (e.g. donors' letter, social media):  YES  NO

## RESPONSABILITES OF PARENTS / GUARDIANS / HOUSE OR CASE MANAGER:

- Submit **completed registration form and payment** before participation begins.
- Ensure all information is accurate and up to date before program start.
- Notify animators in writing and orally of any medication or behaviour plan changes.
- Send participants appropriately dressed for the activity and weather.
- **Do not send participants who are ill or feverish.**
- Provide participants with **valid identification and transportation fare**
- Provide emergency contact updates as needed.
- **Termination for inappropriate behaviour:** if the client behaves in a way that prevents participation in the activities or implementation of the activity, or that endangers their life or the lives of others, we reserve the right to terminate the contract. We also reserve the right to impose conditions for the continuation of attendance including necessity of being accompanied, and/or sharing a PAM (or other essential documents), and/or having an in-person training.

### Trial Period Policy:

Within the first fourteen days of the session, participants may assess whether the selected activity meets their expectations. If desired, they may request a change—subject to availability—or withdraw from the program. Refunds will only be issued during this initial two-week period. **No refunds will be granted for cancellations made after this period.**

**By signing this, you have accepted all the conditions and responsibilities as outlined above.**

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

Form completed by : \_\_\_\_\_ Phone : \_\_\_\_\_

(Relationship to participant:  Parent  Guardian  Case Manager  Other: \_\_\_\_\_)

**PAYMENT INFORMATION:**

Credit Card number: \_\_\_\_\_ Expiry date: \_\_\_\_\_

(To pay by phone. please contact the Accounting at 514-345-1300 x 411 during office hours and **ONLY during the registration period.**)

Cheque (payable to GOLD CENTRE)

Interac e-Transfer to: [accounts@miriamfoundation.ca](mailto:accounts@miriamfoundation.ca)

**Security answer MUST BE: CentreGold**

Invoice requested (please specify who will pay the invoice : \_\_\_\_\_)

Receipt for payment requested

**Please note:** Cash is no longer accepted. For special arrangements, contact Nina Chepurniy.

**LIST OF ACTIVITIES**

ACTIVITY	DATE	HOURS	PRICE

\*If signing up for Bowling, please indicate shoe size: \_\_\_\_\_

TOTAL : \_\_\_\_\_