LEISURE ACTIVITIES – FALL 2026
Registration Form

PARTICIPANT INFORMATION

IMPORTANT :

Please attach a RECENT photo here

Required for ID

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:_____
_____

Miriam
5703, rue Ferrier, Mont-Royal (Québec) H4P 1N3 | 514.345.8330 | info@goldlearningcentre.com

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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: _____

Medication: _____ Dose: _____ Time given: _____

Medication: _____ Dose: _____ Time given: _____

Pharmacy: _____ Phone: _____

Treating physician: _____ Phone: _____

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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 : _____

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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
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 : _____

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