LEISURE ACTIVITIES – WINTER-SPRING 2023

Registration Form

PARTICIPANT PROFILE

IMPORTANT:

PLEASE ATTACH A RECENT PHOTOGRAPH HERE

REQUIRED FOR ID

Participant's name: _____

Date of birth: _____ /_____ /_____ Age: _____
DAY MONTH 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): _____ Relationship to participant: _____

Secondary phone number: _____ Relationship to participant: _____

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, level of autonomy, etc. Please, attach behaviour plan if applicable.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

TRANSPORTATION ABILITIES:

Able to use public transit independently? Yes ☐ No ☐

Familiar bus routes/frequented areas: _____

Miriam Intervention
5703 Ferrier, Mount Royal, QC H4P 1N3
Leisure Activities - 514.345.8330 x 203

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Street safety skills? Yes ☐ No ☐ Comment:

_____

Transport Adapté FILE NUMBER: (if applicable)

_____

MEDICAL INFORMATION:

Medicare card no.: _____ Expiry Date: _____

Health problems (specify):

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

MEDICATIONS: Please 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: _____

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Medication: _____ Dosage: _____ Time given: _____

Pharmacy: _____ Tel. No.: _____

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

CONSENT TO RELEASE OF PHOTOS:

I, the undersigned, authorize the Miriam Intervention/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.: _____

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PAYMENT INFORMATION:

PLEASE NOTE THAT PAYMENT AND COMPLETED REGISTRATION FORMS RECEIVED BEFORE **JANUARY 9, 2023**, THE START OFTHE REGISTRATION PERIOD, WILL **NOT** BE ACCEPTED**.**

Please indicate how you will be paying:

☐ **CREDIT CARD**; Card number: _____ Expiry date: _____

If you would prefer to call this in, please contact Jasmine Kooner (514-345-1300 x 312) or Sarah Lhynn Sevilla (514-345-1300 x 411) during office hours and **ONLY** during the registration period: JANUARY 9 – 13, 2023.

☐ **CHEQUE (payable to Gold Centre)**

☐ **E-TRANSFER** (Send to: accounts@miriamfoundation.ca; password: CentreGold; Sent between JANUARY 9-13, 2023)

*Cash will no longer be accepted; if this is an issue, please contact Nina Chepurniy.

LIST OF ACTIVITIES:

ACTIVITY	DAY	TIME	COST

TOTAL COST: $

_____

OFFICE USE ONLY: Received ____ /____ / ____ Payment _____

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