



# CAMP DE VACANCES ET RÉPITS

## REGISTRATION FORM

PARTICIPANT					
First name		Last name			
Date of birth		Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other
Lives with	<input type="checkbox"/> Main contact <input type="checkbox"/> Secondary contact <input type="checkbox"/> Other :				
SUMMARY HEALTH FORM					
Health ins. number		Exp.			
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		
Ratio	<input type="checkbox"/> Group 1:4 <input type="checkbox"/> Shadowing 1:1 / 1:2		Other deficiency :		
Swimming level	<input type="checkbox"/> None <input type="checkbox"/> Average <input type="checkbox"/>		T-Shirt child	<input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large <input type="checkbox"/> X-Large	
Password for departure		T-Shirt adult	<input type="checkbox"/> Small <input type="checkbox"/> Medium <input type="checkbox"/> Large <input type="checkbox"/> XL <input type="checkbox"/> 2XL		
PARENTS, LEGAL GUARDIANS OR FOSTER FAMILY					
<b>Name Main contact</b>					
Address					
City		Province		Postal	
Home phone		Mobile :			
Relationship with participant :		Email :			
<b>Name Secondary contact</b>					
Address					
City		Province		Postal	
Home phone		Mobile :			
Relationship with participant :		Email			
Name on tax receipts		S.I.N. for RL-24			
OTHER CONTACT IN CASE OF EMERGENCY (Mandatory)					
Name Contact 1:		Tel :		Relation :	
Name Contact 2 :		Tel :		Relation :	
Social worker :		Tel & email :			
How did you hear about the Centre ? <input type="checkbox"/> Reference <input type="checkbox"/> ACQ <input type="checkbox"/> Web site <input type="checkbox"/> School <input type="checkbox"/> CSSS <input type="checkbox"/> Other :					



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## REGISTRATION FORM

I authorize the person responsible to make appropriate decisions pertaining to the health and safety of the participant. I therefore authorize the management to act in my name in case of emergency in order to administer first aid or other medical or surgical help related to the state of health of the participant.

Yes  No

I authorize the Center to use photographs, and interviews of the participant for use in publishing in our brochures, on television or other media.

Yes  No

### CONSENT TO DISCLOSURE AND EXCHANGE OF PERSONAL INFORMATION

**\*\* MANDATORY \*\***

I, undersigned, \_\_\_\_\_, consent to the disclosure and/or exchange of personal information by the staff of the Notre-Dame-de-Fatima Center who wish to disclose and/or exchange relevant data contained in my personal file or the person for whom I am responsible, and/or medical or other records, established with this organization, with the staff or other parties (refer to the Privacy Policy for all details - <https://www.mon-camp.ca/politique-de-confidentialite> or upon request).

At any time, I may withdraw my consent to the disclosure and exchange of information.

I also accept the terms of payment, reimbursement, and registration as they appear on the registration form and website.

\_\_\_\_\_  
Participant's Signature or  
parent or legal guardian

\_\_\_\_\_  
Date

**I WISH TO APPLY FOR FINANCIAL AID FOR THIS PARTICIPANT**

*Please send the completed form and copy of your "Notice of assessment".*

*We will contact you to confirm your eligibility.*

**PLEASE INCLUDE THE FOLLOWING:** Photo Health form

*These forms will be valid for two years*



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# CAMP DE VACANCES ET RÉPITS

## REGISTRATION FORM – AUTHORIZATIONS

### Medication Administration Record – MANDATORY

New measures in place – Medications during camp/respite hours

If your child/dependent adult takes medication during vacation camp and/or respite hours, in order to comply with the new requirements of the National Care Standards in community organizations and respite centres, please read the following:

#### Required Documents (as applicable to your child/dependent adult)

- Contact your pharmacy to obtain the Medication Administration Record (MAR).
- Provide the MAR to the day camp upon arrival.
- Provide a new MAR whenever there is a change in medication.

#### Medications (as applicable to your child/dependent adult)

- Provide medication in Dispill format whenever possible.
- Provide the necessary medication for the entire stay.
- Ensure that each medication (Dispill or non-Dispill) has a pharmacy label identifying the camper, the medication, the dosage, the route of administration, the time of administration, and the expiration date.
- Ensure that the pharmacy labels include clear instructions for the use of the medication.

I confirm that I have read the above “Medication Administration Record – MANDATORY” for my child/dependent adult and, by this consent, authorize the Centre Notre-Dame-de-Fatima to administer medications according to the MAR provided by my pharmacy.

\_\_\_\_\_  
Name of child / dependent adult

\_\_\_\_\_  
Signature of parent(s) or legal guardian(s)

\_\_\_\_\_  
Date



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