



Participant's Information				
First name			Family name	
Language <input type="checkbox"/> Français <input type="checkbox"/> English	Date of birth (yy/mm/dd)	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Health Insurance Number
				Card Expiry Date
Address			Apt.	Telephone – Residence ()
		Town	Postal Code	

Information – parents: first contact		Information – parents: second contact	
Family name and first name:		Family name and first name:	
Social insurance number (for income tax purposes):		Social insurance number (for income tax purposes):	
Full address: (if different from child)		Full address (if different)	
Telephone – Residence: ()	Cellular: ()	Telephone – Residence: ()	Cellular: ()
Telephone – Work: ()	Ext.	Telephone – Work: ()	Ext.
Email :		Email :	
Income Tax Credit : <input type="checkbox"/> 100% to first contact <input type="checkbox"/> 50% - 50% <input type="checkbox"/> 100% to second contact			
1st contact in case of emergency (if parents cannot be reached)		2nd contact in case of emergency (if parents cannot be reached)	
Family name and first name;	Relationship:	Family name and first name;	Relationship:
Telephone: ()		Telephone: ()	

HEALTH / MEDICATION (section to complete)
Does your child have a medical condition we should be aware of: (asthma, diabetes, etc.)? Yes <input type="checkbox"/> No <input type="checkbox"/>
Specify: _____
Does your child take medication daily? Yes <input type="checkbox"/> No <input type="checkbox"/>
Specify : (Name of medication, dose and side effects) _____
Does your child have allergies? Yes <input type="checkbox"/> No <input type="checkbox"/> What type? _____ Last Flare-up : Year / mm _____
Severity : _____
Does he/she have a functioning dose of adrenaline (Epipen, Ana-kit) at his/her disposal? Yes <input type="checkbox"/> No <input type="checkbox"/> n/a <input type="checkbox"/>
If yes, do you authorize the camp personnel to administer the dose of adrenaline? Yes <input type="checkbox"/> No <input type="checkbox"/> n/a <input type="checkbox"/>
I authorize the day camp staff to administer and assist with medication for my child. Yes <input type="checkbox"/> No <input type="checkbox"/> n/a <input type="checkbox"/>
Other particulars that should be brought to our attention in regards to your child's character or behaviour? Yes <input type="checkbox"/> No <input type="checkbox"/>
Specify : _____
I authorize the day camp staff to provide my child with the necessary medical attention if required, as well as transportation by ambulance. If management cannot reach me or my emergency contacts, I authorize the doctors to provide ALL the necessary medical attention.
I certify that the information provided on this form is correct and that I have read the aforementioned permissions.
Initials: _____

I hereby authorize the Town to take and use photos of my child for promotional purposes.
 Yes No

I am completely aware of the refund terms and methods and I accept them.

Signature of the parent: _____ Date : _____

TEEN OUTINGS 13-15 years old

Summer Day Camp – Registration form 2020 – **Registration in person only**

Participant's First Name

Participant's Last Name

TEEN OUTINGS		Cost for RESIDENTS	Cost for NON RESIDENTS		TOTAL For the Package
CHECK The selection	DATES				
	July 9 th ESCAPE ROOM	\$40	\$50		
	July 23 rd AQUAZILLA	\$40	\$50		
	August 6 th VOILES EN VOILES	\$40	\$50		
GRAND TOTAL					

RESERVED FOR ADMINISTRATION

Mode de paiement : chèque carte Débit carte Visa carte MasterCard

1^{er} Chèque à l'inscription (300 \$ et moins): Date _____ Montant : _____

1^{er} Chèque postdaté (300 \$ à 599 \$): Date du 30 avril 2020. Montant : _____

2^e Chèque postdaté (600 \$ à 899 \$): Date du 21 mai 2020. Montant : _____

3^e Chèque postdaté (900 \$ +): Date du 18 juin 2020. Montant : _____

1^{er} enfant : nom _____ Montant : _____

2^e enfant : nom _____ Montant : _____

3^e enfant : nom _____ Montant : _____

**Grand total de la
Famille:**

NOTE FOR ADMINISTRATION :
