

**Mission Aboriginal Family Place Registration Form
2011-2012**

Child's Name	Birth Date	Register First Nation Band or Self-Identified

Parent's Name	Birthday (month/day)	First Nation Band
Phone:	Message/Cell:	
Address:		<input type="checkbox"/> On-reserve <input type="checkbox"/> Off-reserve
Family Status	<input type="checkbox"/> Married/Common Law <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
Caregivers Name:	Phone:	

Emergency Information		
Family Doctor:	Phone:	
Permission to call Dr. and/or Ambulance in case of an Emergency?	Yes	No
Emergency Contact #1:	Phone:	
Emergency Contact #2:	Phone:	
Parent Allergies:		

Health Information				
Child's Name	Medical #	Status #	lbs	M/F
Does your child(ren) have any medical problems (breathing, epilepsy, etc.?) or Allergies? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, please specify Child's name: Specifics: Child's name: Specifics:				
Is your child's immunization up to date? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Not immunized If no, please explain:				
Information we should know about your child (special diet, behaviour, speech, vision, hearing, etc.) 				

RELEASE OF ALL CLAIMS AND AGREEMENT TO INDEMNIFY

I understand that my child(ren) must be under my or my caregiver's supervision at all times while participating in the Mission Aboriginal Family Place.

I, _____ hereby waive and release employees, volunteers, contractors and its agents and all liability for any injury, loss or illness suffered by myself or my children, arising directly or indirectly by any reason, during the transportation to and participation in the Mission Aboriginal Family Place.

I give permission for Mission Aboriginal Family Place to include my family and I in any pictures, videos, calendars, web site, display boards, during our on going activities throughout the year. YES NO

Please sign and date below:

Signature of Parent/Guardian _____ Date:

Signature of Witness _____ Date:

Any Additional Information:

Office Use Only: Years of Participation: 1st____ 2nd____ 3rd____ 4th____ 5th

Area (Please Circle): Mission Leq'a:mel Deroche Matsqui

Date Registered: _____ Staff Signature:

Date entered into Data Base: _____ Custody Papers on File: Yes No

Immunization checked: Y/N

Date Immunization Records put on file: