

Last Name: \_\_\_\_\_ Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 Province: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_  
 Postal Code: \_\_\_\_\_ Email: \_\_\_\_\_  
 Male  Female  Date of birth: (dd/mm/yyyy) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Name of parents or guardians:  
 Mother's last: \_\_\_\_\_ Mother's first: \_\_\_\_\_  
 Father's last: \_\_\_\_\_ Father's first: \_\_\_\_\_  
 How did you hear about us? \_\_\_\_\_

**Payments:**

Payments may be forwarded with completed copy of this form via regular mail. Places are not reserved without payment. I submit payment of...  
 Registration fee of \$150.00, post-marked before, or after July 1<sup>st</sup>  
 Optional bursary donation of: \$ \_\_\_\_\_  
 Total: \$ \_\_\_\_\_

**Medical Form:**

Last Name: \_\_\_\_\_ Name: \_\_\_\_\_  
 Email: \_\_\_\_\_ Home parish: \_\_\_\_\_  
 Youth group: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Mother's maiden name: \_\_\_\_\_  
 Medicare n#: \_\_\_\_\_ Card expiry date: \_\_\_\_\_  
 Approx. date of last dental exam: \_\_\_\_\_  
 Serious Allergies: \_\_\_\_\_  
 Usual treatments: \_\_\_\_\_  
 Specify any communicable diseases in past 12 months: \_\_\_\_\_

List Medications taken: \_\_\_\_\_

Please indicate below any medical condition to which you are subject, diagnosed as:  
 Arthritis  Ear Trouble  Migraines  Skin Disorders  
 Anxiety attacks  Epilepsy  Nosebleeds  Sleepwalking  
 Asthma  Fainting  Nightmares  Other: **Please list below**  
 Others: \_\_\_\_\_

Have you ever had:  Appendicitis  Hepatitis  Mononucleosis  
 Are you:  ADHD  ADD  
 Other behavior or attention disorder (**please specify**) \_\_\_\_\_

Poliomyelitis  Rheumatic Fever  
 Are you taking Ritalin: Yes  No   
 Please note any illness, injuries, recent operations that have been advised that are not listed above: \_\_\_\_\_

Have you seen or been under the care of a therapist on a regular basis, in the past year?  
 Yes  No  
 For what reason? \_\_\_\_\_

Are you a vegetarian? Yes  No  Other special dietary needs: \_\_\_\_\_