



1200 Cartier Avenue, Coquitlam BC, V3K 2C3  
 (P) 604.933.6166 (F) 604.933.6168  
 www.placemaillardville.ca

**REGISTRATION FORM Page 1**

# Children/Youth Waiver

Register by phone at 604-933-6166 or in person at Place Maillardville, 1200 Cartier Avenue, Coquitlam.  
 For more information, visit our web site at [www.placemaillardville.ca](http://www.placemaillardville.ca)

**REGISTRANT INFORMATION**

Program Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Family Name: \_\_\_\_\_

Male  Female

Emergency Contact Name:  
 \_\_\_\_\_

Emergency Contact Phone:  
 \_\_\_\_\_

Indicate who will pick up your child:

Name: \_\_\_\_\_

relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_

relationship to child: \_\_\_\_\_

Please let us know if someone else will pick up your child/youth on a specific day.

**HEALTH AND MEDICAL INFORMATION**

Please indicate if child experiences or has experienced any of the following:

CONDITION	Y	N	DETAILS
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	_____
Physical Limitations	<input type="checkbox"/>	<input type="checkbox"/>	_____
ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
.. Peanuts	<input type="checkbox"/>	<input type="checkbox"/>	EPI Pen .. Yes <input type="checkbox"/> .. No <input type="checkbox"/> _____
.. Bee Stings	<input type="checkbox"/>	<input type="checkbox"/>	EPI Pen .. Yes <input type="checkbox"/> .. No <input type="checkbox"/> _____
.. Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
.. Medications	<input type="checkbox"/>	<input type="checkbox"/>	_____
.. Food	<input type="checkbox"/>	<input type="checkbox"/>	_____
.. Latex	<input type="checkbox"/>	<input type="checkbox"/>	_____
Major Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Behavior Issues	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tourettes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Privacy Note:**

Information on **Page 1** of the form will be disclosed only to instructors.

Personal information on **Page 2** of form will be secured at Place Maillardville Community Centre only and will be destroyed at program end.

Initials: \_\_\_\_\_



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REGISTRATION FORM Page 2

# Children/Youth Waiver

Program Name: \_\_\_\_\_  
First Name: \_\_\_\_\_ Family Name: \_\_\_\_\_ Date of Birth   /  /   Age:     Male  Female  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Mother's/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Father's/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ BC Health No.: \_\_\_\_\_

## PAYMENT

Enclosed:  Cash/Cheque or  Credit Card

*If paying by cheque full payment is due **two weeks** prior to first day of class.*

**If paying by credit card, please complete:**  Visa  MasterCard Credit Card Number: \_\_\_\_\_

Expiry Date: \_\_\_\_\_ Card Holder's Name: \_\_\_\_\_ Signature: \_\_\_\_\_

**OFFICE USE ONLY**  Cash / Debit  Cheque  Visa/MC Initials: \_\_\_\_\_ Process Date: \_\_\_\_\_

I/We agree that our son/daughter will follow all reasonable instructions and directions of the program instructor(s) in connection with the operation of Place Maillardville.

I/We release, remise and forever discharge Place Maillardville staff, program instructor(s) and partners of Place Maillardville of and from all manner of actions, claims and demands of whatever nature which result from any accidental injury, loss of expense sustained, arising out of or in any way connected with participation in any Place Maillardville program or event.

In the event that our son/daughter is injured, ill or in need of medical attention and I/We are unable to be contacted, I/We authorize Place Maillardville staff, program instructor(s) and volunteers to seek medical attention on my/our behalf. I/We authorize Place Maillardville to use any photographs taken of our son/daughter while participating in Place Maillardville programs, services and event for Place Maillardville brochures and promotional materials.

\_\_\_\_\_  
Parent/Guardian Signature Date \_\_\_\_\_