Intake Form Completed: Yes / No Paid: Yes/No Receipted: Yes/No

Cerebral Palsy Association in Alberta

Registration Form

Start/End Date: _____

Name: _____ Date of Birth: _____

Address:_____ Postal Code:_____

Phone (Days): _____ Phone (Evenings):_____

Emergency Contact Name: _____

Relationship: _____ Phone (Days):_____

Phone (Evenings): _____ Phone (Cell): _____

Will Aide or Companion be accompanying member to the program: Yes / No

Name of Aide or Companion: _____

Name of Agency: _____

Phone (Cell): _____

Personal Information (for Emergency use only)

Alberta Health Care Number:_____

Doctor's Name: _____

Medications currently prescribed and dosages: _____

_____

Are there any behavioral issues/problems that we should be aware of: Yes / No

If yes, what: _____

_____

Any other information that would be of assistance to our staff or your client:_____

_____

Please fax back to Kim Henye (780) 471-0855