

<b>Participant Name:</b>	<b>Phone:</b>	<b>D.O.B:</b>
Full Address:		
<b>Transportation Arrangements:</b>		
<input type="checkbox"/> DARTS # (if applicable): <span style="margin-left: 200px;"><input type="checkbox"/> HSR</span> <span style="margin-left: 50px;"><input type="checkbox"/> Other:</span>		

<b>Contact Name:</b>	<b>Phone:</b>
Full Address <small>(if different from above):</small>	
Relationship:	Email:
<b>Billing Name/Address</b> <small>(if different from above):</small>	

**In the Know & On the Go Selections:**

Activity	Start Date	End Date	Fee

I give permission to Community Living Hamilton to take payment from CLH Administered Passport Funding. Yes  No

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

Signature: \_\_\_\_\_

Total:

**This program is designed for adults 18 years of age and older who can participate independently with a ratio of 1 staff to 6 participants.**

For any other questions, please contact:

**Kathi Soules, Manager, Client Services**

Phone: 905-528-0281 x249

Please email forms to: [directfundingforms@clham.com](mailto:directfundingforms@clham.com)

Or Mail: 191 York Blvd, Hamilton, ON L8R 1Y6

**Please DO NOT send payment with registration form. Invoice will follow.**

**For office use only.**

Method of payment:

Fee For Service (Direct Billing)

Passport – Agency Services

Other

<b>Communication Information:</b>	
<input type="checkbox"/> Verbal <input type="checkbox"/> Non-verbal <input type="checkbox"/> Gestures/ Sign Language <input type="checkbox"/> Communication system	
<b>Medical/Behavioural Information:</b>	
Does the client have seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, please describe:	
Does the client require behavioural re-direction? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list strategies that would be helpful:	
Is there a Behaviour Support Plan in place? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If yes please attach</small>	
We are <b>unable</b> to administer medication or support any medical care needs in these supported leisure programs. Are there any other needs you want us to know about (e.g. asthma, hearing, sight)?	
<b>Allergy Information:</b>	
Do you have life threatening allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No                      Do you carry an Epipen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Identify:	
Any other allergies:	
<b>Mobility Information:</b>	
Mobility aids? <input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Cane(s) <input type="checkbox"/> Staff Guide <input type="checkbox"/> N/A	
Mobility/ transfer support? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If yes please describe</small>	
Support for personal hygiene/ toileting? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If yes please explain</small>	
Assistance with eating and drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If yes please explain</small>	
I give permission to Community Living Hamilton to take my photograph for identifications purposes and for any promotional purpose <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Alternate Contact Information: (Reachable During Activity)</b>	
Name:	Phone:
Relationship:	Work/Mobile #:
Name:	Phone:
Relationship:	Work/Mobile #:

***At times our programs may be unable to accommodate every registrant.***

***We will contact you directly to discuss any questions or concerns.***

All activities are held based on the number of registrants. Fees support staffing, transportation and other costs.

We are not able to provide a refund if registered individuals cannot attend any scheduled

In The Know or On The go sessions.