



PO Box 8093
Halifax, NS
B3K 5L8
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Program Registration Form
Team Possibles/Friday Night Socials/Family Camp/Play Group

Personal Information

Participant Name: _____

Gender: ___ Date of Birth: d/m/y_____

Parent/Guardian Name (s): _____

Email Address: _____

() Home Phone: _____

() Work Phone: _____

() Cell Phone: _____

() Preferred method of contact:

Address:

OTHER Emergency Contacts:

Name: _____

Phone: _____ Work/Cell: _____

Name: _____

Phone: _____ Work/Cell: _____

Down Syndrome Related Information

Secondary diagnosis: _____

Please provide detailed information regarding the diagnosis that will help us work with the participant effectively:

Tertiary diagnosis: _____

Please provide detailed information regarding the diagnosis that will help us work with the participant effectively:

Medical Information

Food allergies: Yes or No (If yes, please explain:)

Please explain any medical conditions or health concerns and any special instructions:

Atlantoaxial instability Screening: yes () no () Date: _____

Details/ Special instructions: _____

Speech, hearing and communication information

Please explain any speech, hearing, communication and language needs, and any special instructions: ASL: y () n () Some ()

Flight Risk: y () n ()

Please explain any concerns, circumstances, observations and any special instructions:

OTHER Information/description:

Physical Information/description:

Height: inches _____

Weight: lbs./Kgs _____

Hair/ eye colour: _____

Attach current photo: