P. O. Box 4462
Sussex, NB E4E 5L6
www.cpfnb.com

Tel : 506-432-6584
Tel : 1-877-273-2800
Fax : 506-432-6751

Canadian Parents for French NB

Nautical Camp Registration

Campers name:_____

Male Female Age_____

Birth date _____

Medicare #: _____Expiry _____

Camp requested: _____

Camp date: _____ Fee $_____

For new membership **add** $ 25.00

OR

Membership #_____

TOTAL: $_____

A deposit of $100/person
is required with the registration.
(no refund if cancelled or early quitting)

Total amount must be paid 15 days before camp. If your child quits before the end of the camp, only the unused portion will be refunded. *Membership to CPFNB is required.*

Cheque payable to: **Canadian Parents for French NB**

Include the cheque with the application and health forms, mail to:
Canadian Parents for French NB
P. O. Box 4462,
Sussex, NB E4E 5L6

Parental/guardian Consent

I hereby release CPF, its officers, employees and contracted staff connected with CPF camps from all liability for damage resulting from the participation of my child or ward in CPF camps. During these activities pictures have been taken. To help promote the camp, we would like to ask your permission to include photo(s) of your child(ren).

_____ _____
date parent/guardian signature

PARENTS/GUARDIANS INFORMATION

Name (mother)_____

Name (father) _____

Street Address_____

City _____ Province _____ Postal Code _____

Home Phone: _____ Work Phone: _____ Cell: _____

E-mail: _____

Nautical Camp Medical Form

Name _____

Male Female Age_____

Birth date _____

Medicare#_____ Expiry _____

Name (mother)_____

Name (father) _____

Address_____

City _____

Province _____Postal Code _____

Home Phone: _____

Work Phone: _____

Cell: _____

Your child suffer from:

- ☐ Asthma
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Incontinence
- ☐ H.I.V.
- ☐ Vision trouble
- ☐ Skin sensibility
- ☐ Allergies

Allergies

Details :

Must take medication

Details :

Other

Details :

Year of last tetanus vaccination ☐

Year of last measles vaccination ☐

Name of 2 family members we can contact if we can't get hold of the parents:

Name_____

Phone:_____

Name: _____

Phone: _____

Which medication do you authorize the camp staff to give to your child:

- ☐ Acetaminophen (Tylenol, tempra, etc.)
- ☐ Anti-histamine (Benadryl, Claritin, Allegra, Reactine, Phenergan)
- ☐ Anti-inflamatory (Advil)
- ☐ Antibiotic(Polysporin, Neosporin, Baciguent)
- ☐ Dimenhydrinate (Gravol)
- ☐ Cough Medicine
- ☐ Other

Comments

IMPORTANT

By signing this medical record, I authorize the doctor, nurse and authorized staff to administer first aid when necessary. In the event that the camp personnel is unable to reach a member of the family, I authorize an emergency surgical intervention should the need arise.

Signature _____

Date _____