

Participant's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Prov: ON Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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In Case of Emergency:

\_\_\_\_\_ may be contacted at \_\_\_\_\_.  
(name) (phone)

Health Card #: \_\_\_\_\_

Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

On Medication: Yes No If yes, what type: \_\_\_\_\_

Allergies: Yes No If yes, what type: \_\_\_\_\_

Does the individual have problems with: Hearing Speech Sight

Other: \_\_\_\_\_

**NOTE:** If available, a copy of the individual's Psychological Assessment must be provided.

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Future Plans:

- Disability Pension
- Volunteering
- Education – GED
- Education – College
- Education – University
- Military
- Working

High School Status:

- Did not complete high school
- Currently in high school
- Completed high school

**PLEASE CONTINUE ON THE NEXT PAGE...**

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_, agree to and provide permission for the photographic, video, and audio recording of myself throughout the SOAR:HS Program offered by the Learning Disabilities Association of Windsor – Essex County.

I accept and agree that the ownership of any recordings will be kept by the Learning Disabilities Association of Windsor – Essex County. I authorize the use or reproduction of any recordings referred to above for any reasonable purpose\*. I understand that recordings will only be used for positive public education purposes.

\* “Purposes” for photographs, video, and audio recordings includes use or publication in: websites, social media feeds, workshop presentations, television clips, brochures, and magazines for the use of program promotion or program summary.

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

I have read the information on the registration form and declare it to be true:

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

**FOR OFFICE USE ONLY**

Is participant an Ontario Works recipient? Yes \_\_\_ No \_\_\_

If yes, OW Caseworker Name: \_\_\_\_\_ Number: \_\_\_\_\_

\_\_\_ SOAR:HS Amount Paid: \$ \_\_\_\_\_ Cash \_\_\_ Cheque \_\_\_ Date: \_\_\_\_\_

\_\_\_ Membership Amount Paid: \$ \_\_\_\_\_ Cash \_\_\_ Cheque \_\_\_ Date: \_\_\_\_\_

Has the psychological assessment been provided? Yes \_\_\_ No \_\_\_