PASSPORT OPPORTUNITIES REGISTRATION FORM

Please return completed registration form prior to closing of on-line registration

First Name:			Last Name:	
Date of Birth:			Gender: ☐Male ☐Female	
Street:			Unit:	
City:			Postal Code:	
Phone:	Cell:		Email:	
Health Card #:			Mobility Plus #:	
Allergies:		☐ Yes	☐ No	
Medications: See page 3		☐ Yes	☐ No	
Fears:		☐ Yes	☐ No	
Diet Restrictions:		☐ Yes	☐ No	
Assistance with Mobility:		☐ Yes	☐ No	
Assistance with Behaviours:		☐ Yes	☐ No	
Asthma:		☐ Yes	☐ No	
High Blood Pressure:		☐ Yes	☐ No	
Heart Condition:		☐ Yes	☐ No	
Seizures:		☐ Yes	☐ No	
Diabetic:		☐ Yes	☐ No	
		☐ Type 1	☐ Type 2 (write explanation below)	
Assistance with Feeding:		☐ None	☐ Minimal	☐ Total ☐ G tube
Assistance with Toileting:		☐ None	☐ Minimal	☐ Moderate ☐ Total
Communication:		☐ Verbal	☐ Non Verbal	☐Assistive Devices
Additional support Staff required		☐ Yes (if yes see below)		☐ No if yes see below
Bring your own		☐ Yes	☐ No	
Need additional staff supplied for an additional cost		☐ Yes	☐ No	

Information we need to best support you: (seizures, medications, allergies, fears, preferences)

2749 Kingsway Dr. Kitchener Ontario N2C 1A7 Phone: 519-893-6200 Fax: 519-893-9034

EMERGENCY CONTACT INFORMATION:	
Contact 1	Contact 2
Name:	Name:
Relationship:	Relationship:
Home Phone:	Home Phone:
Cell:	Cell:

MY MEDICATIONS

Medication must be in its original container, clearly marked with the name of the person it is prescribed for, date of prescription, name of medication, dose, frequency, how it is to be taken, and name of prescribing provider. You may want the Pharmacist to provide you with two bottles when filling the prescription: one for Passport opportunities and one to keep at home.

Name of Medication	Dosage	Frequency	Strength	Times to be Given