



SESSION REGISTRATION FORM

P.O. Box 1820 205-7th Ave. N. Creston BC, V0B 1G0 ph. 250-428-2296 fax 428-2297

DATE OF SESSION: *September 3rd, 2008 – October 10th, 2008*

NUMBER OF WEEKS: 6 weeks = \$90 plus the annual \$20 insurance fee

Name of Rider: _____

Address: _____

Phone: _____ email: _____

Legal Guardian: _____

Address: _____

Phone: _____ email: _____

I am registering the above rider for the above noted session. All the appropriate forms have been completed, signed, submitted and are on file with CDSCL.

- Intake/Referral for Services (where applicable)
- Rider Application/Profile Form (mandatory)
- Atlanto-axial X-Ray Verification for riders with Down Syndrome (where required)
- Consent for release of information (where applicable and/or as required)
- Physician Referral Form (mandatory)
- Liability Release/Waiver (mandatory)
- Photograph/Video Release/Non Consent Form (mandatory)
- Authorization/Non Authorization for Emergency Medical Treatment (mandatory)
- Emergency Profile (mandatory)

The following form is required on an annual basis:

- Physician Referral Form

Interested in Rider Level Programs: yes no Which one (if known) _____

Signature of Rider: _____ Date: _____

Signature of Legal Guardian: _____ Date: _____

Signature of Witness: _____

Signature of Program Director: _____ Date: _____

