epilepsy south central ontario

Family Surname

Family & Youth Conference September 13-15, 2019

Welcome!

Welcome to the fourth annual Family & Youth Conference! The Family & Youth Conference takes place at Circle Square Ranch 1645 Colborne Street East Brantford ON from September 13th to 15th.

All meals, sleeping arrangements, activities, and presentations are included in the registration cost for this event. Epilepsy South Central Ontario has worked hard to subsidize the cost to keep this amazing event affordable for families.

Please note that accommodations are shared.

Rooms sleep between 4-- 7 single beds in one room. We will match individuals and families accordingly to ensure a comfortable and enjoyable stay. The Family & Youth Conference Coordinator is available to speak to regarding questions you may have about shared accommodations.

The Family & Youth Conference is a three day event which is packed full of educational presentations surrounding Epilepsy, fun activities and offers a well needed weekend away in the peaceful serenity of country scenery. We have programs that take place for the adults, the youth and the children, all in which are specific to the age categories. Of course we also have activities for everyone to enjoy and come together such as nightly camp fires and a Saturday Night dance party! If you have not previously attended one of the Family & Youth Conferences, know you are in for an incredible weekend!

Please complete this fillable PDF Registration Form – here's how:

- Complete the form on your computer and then save it.
- Email it to andrea@epilepsysco.org as an attachement.
- MANDATORY medical release forms and Social Media release forms must be completed for every person attending the conference
- Early bird registration closes July 1st 2019 - payment must be received by July 1st
- Regular registration closes August 29th at 4:00 pm - payment must be made by August 29th.

Please note: For children and youth taking part in horseback riding, waiver forms from Circle Square Ranch will be provided upon arrival at the event to be completed by participants/ guardians in order to take part in this activity.

Sincerely,

Andrea Dent
Family & Youth Conference Coordinator

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Retreat Fees

Early Bird Registration

Please check the appropriate box.

☐ All weekend individual $35.00 / person.

☐ All weekend Family of 5 $150.00

☐ Saturday Only (lunch will be provided) $25.00 / person.

Number of Family Members Attending: __________ x Cost / Person $__________

Total Cost: $______________

Regular Registration

Please check the appropriate box.

☐ All weekend individual $45.00 / person.

☐ All weekend Family of 5 $180.00

☐ Saturday Only (lunch will be provided) $30.00 / person.

Number of Family Members Attending: ___ __ x Cost / Person $______ Total Cost: $__________

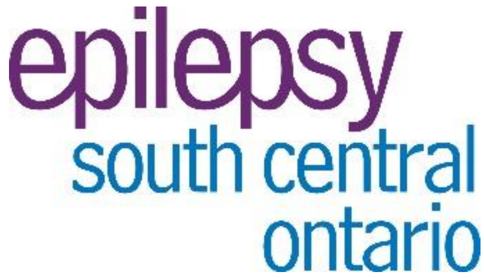
Forms of Payment

If making payment by credit card, please call the office and ask for David ext 203

We will accept:

- *Cash*
- *Debit*
- *Visa*
- *MasterCard*
- *American Express*
- *Cheques payable to:* ***Epilepsy South Central Ontario***

E-transfer is also available to make payment. To pay by e-transfer please email the money to finance@epilepsysco.org, please include your family name in the message section of the e-transfer. You must then send a separate email to finance@epilepsysco.org with your family name and the password for the e-transfer. Please note all payments must be received before registration closes.



2155 Dunwin Drive, Unit 5,
Mississauga, Ontario L5L 4M1
Main Line: 905-450-1900 / Halton: 289-627-1855
Brantford: 226-227-2193 / Hamilton: 289-639-8393

351 Louisa Street, Unit B
Kitchener, Ontario N2H 5N1
K-W Guelph: 519-745-2112

ehph.org / EpilepsySCO.org Charity # 80288 6218 RR0001

Registration Forms

Adult #1: Name: ____ Age: _______________

Phone number: ______________________________ E-mail: ___________________________
(*Circle home or cell*)

Please indicate dietary requirements. Gluten Friendly ☐ Lactose Free ☐ Vegetarian ☐

Adult #2: Name: ____ Age: _______________

Please indicate dietary requirements. Gluten Friendly ☐ Lactose Free ☐ Vegetarian ☐

Adult #3: Name: ____ Age: _______________

Please indicate dietary requirements. Gluten Friendly ☐ Lactose Free ☐ Vegetarian ☐

Adult #4: Name: ____ Age: _______________

Please indicate dietary requirements. Gluten Friendly ☐ Lactose Free ☐ Vegetarian ☐

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Child / Youth #1

Name: ________________________________ Age: ____________________

Does your child require one on one support? ☐ Yes ☐ No
If yes, will you be providing someone to act as one on one support for your child? ☐ Yes ☐ No

Please indicate dietary requirements. Gluten Friendly ☐ Lactose Free ☐ Vegetarian ☐

Child / Youth #2

Name: ________________________________ Age: ____________________

Does your child require one on one support? ☐ Yes ☐ No
If yes, will you be providing someone to act as one on one support for your child? ☐ Yes ☐ No

Please indicate dietary requirements. Gluten Friendly ☐ Lactose Free ☐ Vegetarian ☐

Child / Youth #3

Name: ________________________________ Age: ____________________

Does your child require one on one support? ☐ Yes ☐ No
If yes, will you be providing someone to act as one on one support for your child? ☐ Yes ☐ No

Please indicate dietary requirements. Gluten Friendly ☐ Lactose Free ☐ Vegetarian ☐

Child / Youth #4

Name: ________________________________ Age: ____________________

Does your child require one on one support? ☐ Yes ☐ No
If yes, will you be providing someone to act as one on one support for your child? ☐ Yes ☐ No

Please indicate dietary requirements. Gluten Friendly ☐ Lactose Free ☐ Vegetarian ☐

NOTE:

The term “Child” is considered between the ages of 5 years to 13 years old
The term “Youth” is considered between the ages of 14 years and 30 years old
The term “Adult” is considered above the age of 31 years old.

This determination is based on our Sunny Days Camp, Youth Empowerment Program and Client Care Services.

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Photography Waiver

This form must be completed for each individual attending the retreat.

NAME 1: ____

NAME 2: ____

NAME 3: ____

NAME 4: ____

NAME 5: ____

I hereby give Epilepsy South Central Ontario permission to use my image, my name and likeness for any purposes in connection with Epilepsy South Central Ontario and its activities, which may include but not limited to advertisements, marketing, advertising, print materials, social media, agency web site and/or any other form of promotional materials as deemed necessary by Epilepsy South Central Ontario.

Epilepsy South Central Ontario may crop, alter or modify images of me and combine such images with other images, text, audio recordings and graphics without prior notification. Any such changes will be done with respect to the person, and ideally done for the aforementioned purposes.

I acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in Epilepsy South Central Ontario's marketing materials.

I hereby release Epilepsy South Central Ontario, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

I, ____ am competent to sign this contract in my own name or in the name of my child as listed above. I have read and understood this form prior to signing it, and am aware that by signing this consent I am giving permission to Epilepsy South Central Ontario to use my image for the purposes listed above. I also acknowledge that this is a binding and legal document and my not be altered without the express consent and signature of an Epilepsy South Central Ontario representative.

______________________	______________________
Date	Witness Name (please print)
______________________	______________________
Authorizing Signature	Witness Signature

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Medical Release Form #1

Epilepsy South Central Ontario believes that safety and the wellbeing of its clients are a prime concern.
The purpose of this form is to assist any qualified medical person in case of a medical emergency.
This form must be completed for each individual attending the retreat.

Health Card Number: ____

Name: ____

Date of Birth: ______________________________ Age: ______________________

Address: ____

Phone Number (indicate home or cell):______________________________________

Emergency Contact Name & Relation: ____________________ Phone Number: ________________

Do you have epilepsy? ☐ Yes ☐ No If so, please indicate the type of seizure, frequency and the duration of the seizure:

____

Allergies (Please indicate how severe):______________________________________

Are you bringing an EpiPen? ☐ Yes ☐ No Location of EpiPen during the retreat: ____________________

Other medical concerns we should be aware of: ______________________________

______________________ requires the following medication(s) during the Family & Youth Retreat hours:
(Name person requiring medication)

Medication	Dosage & Type (liquid, pill etc.)	Time of Day

Prescribing Dr. (name): ____________ Phone: __________ ☐ GP ☐ Neurologist ☐ Other: __________
Prescribing Dr. (name): ____________ Phone: __________ ☐ GP ☐ Neurologist ☐ Other: __________

I agree to release any indemnify and save harmless Epilepsy South Central Ontario and its employees from any and against all claims with respect to the costs, losses, damage or injury arising by reason of the administration of medication to my child as requested above.

______________________________ ______________________
Signature (Parent/Guardian) Date

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Medical Release Form #2

Epilepsy South Central Ontario believes that safety and the wellbeing of its clients are a prime concern.
The purpose of this form is to assist any qualified medical person in case of a medical emergency.
This form must be completed for each individual attending the retreat.

Health Card Number: ____

Name: ____

Date of Birth: ______________________________________ Age: __________________________

Address: ____

Phone Number (indicate home or cell):____

Emergency Contact Name & Relation: _______________________ Phone Number: ____________________

Do you have epilepsy? ☐ Yes ☐ No If so, please indicate the type of seizure, frequency and the duration of the seizure:

____

Allergies (Please indicate how severe):____

Are you bringing an EpiPen? ☐ Yes ☐ No Location of EpiPen during the retreat: ________________________

Other medical concerns we should be aware of: _____________________________________

__________________________ requires the following medication(s) during the Family & Youth Retreat hours:
(Name person requiring medication)

Medication	Dosage & Type (liquid, pill etc.)	Time of Day

Prescribing Dr. (name): ____________ Phone: __________ ☐ GP ☐ Neurologist ☐ Other: __________
Prescribing Dr. (name): ____________ Phone: __________ ☐ GP ☐ Neurologist ☐ Other: __________

I agree to release any indemnify and save harmless Epilepsy South Central Ontario and its employees from any and against all claims with respect to the costs, losses, damage or injury arising by reason of the administration of medication to my child as requested above.

__________________________________ ____________________
Signature (Parent/Guardian) Date

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Medical Release Form #3

Epilepsy South Central Ontario believes that safety and the wellbeing of its clients are a prime concern.
The purpose of this form is to assist any qualified medical person in case of a medical emergency.
This form must be completed for each individual attending the retreat.

Health Card Number: ____

Name: ____

Date of Birth: ______________________________ Age: ______________________

Address: ____

Phone Number (indicate home or cell):____

Emergency Contact Name & Relation: _________________________ Phone Number: _______________

Do you have epilepsy? ☐ Yes ☐ No If so, please indicate the type of seizure, frequency and the duration of the seizure:

____

Allergies (Please indicate how severe):____

Are you bringing an EpiPen? ☐ Yes ☐ No Location of EpiPen during the retreat: ____________________

Other medical concerns we should be aware of: ______________________________________

____________________ requires the following medication(s) during the Family & Youth Retreat hours:
(Name person requiring medication)

Medication	Dosage & Type (liquid, pill etc.)	Time of Day

Prescribing Dr. (name): _______________ Phone: _____________ ☐ GP ☐ Neurologist ☐ Other: ____________
Prescribing Dr. (name): _______________ Phone: _____________ ☐ GP ☐ Neurologist ☐ Other: ____________

I agree to release any indemnify and save harmless Epilepsy South Central Ontario and its employees from any and against all claims with respect to the costs, losses, damage or injury arising by reason of the administration of medication to my child as requested above.

______________________________ Signature (Parent/Guardian)

_______________ Date

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Medical Release Form #4

Epilepsy South Central Ontario believes that safety and the wellbeing of its clients are a prime concern.
The purpose of this form is to assist any qualified medical person in case of a medical emergency.
This form must be completed for each individual attending the retreat.

Health Card Number: ____

Name: ____

Date of Birth: ______________________________ Age: ______________________

Address: ____

Phone Number (indicate home or cell):______________________________

Emergency Contact Name & Relation: ______________________ Phone Number: ______________________

Do you have epilepsy? ☐ Yes ☐ No If so, please indicate the type of seizure, frequency and the duration of the seizure:

____

Allergies (Please indicate how severe):______________________________

Are you bringing an EpiPen? ☐ Yes ☐ No Location of EpiPen during the retreat: ______________________

Other medical concerns we should be aware of: ______________________________

______________________ requires the following medication(s) during the Family & Youth Retreat hours:
(Name person requiring medication)

Medication	Dosage & Type (liquid, pill etc.)	Time of Day

Prescribing Dr. (name): ______________ Phone: ____________ ☐ GP ☐ Neurologist ☐ Other: ____________
Prescribing Dr. (name): ______________ Phone: ____________ ☐ GP ☐ Neurologist ☐ Other: ____________

I agree to release any indemnify and save harmless Epilepsy South Central Ontario and its employees from any and against all claims with respect to the costs, losses, damage or injury arising by reason of the administration of medication to my child as requested above.

______________________________ ______________________
Signature (Parent/Guardian) Date

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Medical Release Form #5

Epilepsy South Central Ontario believes that safety and the wellbeing of its clients are a prime concern. The purpose of this form is to assist any qualified medical person in case of a medical emergency.
This form must be completed for each individual attending the retreat.

Health Card Number: ____

Name: ____

Date of Birth: ______________________________ Age: ______________________

Address: ____

Phone Number (indicate home or cell):______________________________

Emergency Contact Name & Relation: ______________________ Phone Number: ______________

Do you have epilepsy? ☐ Yes ☐ No If so, please indicate the type of seizure, frequency and the duration of the seizure:

____

Allergies (Please indicate how severe):______________________________

Are you bringing an EpiPen? ☐ Yes ☐ No Location of EpiPen during the retreat: ______________________

Other medical concerns we should be aware of: ______________________________

______________________ requires the following medication(s) during the Family & Youth Retreat hours:
(Name person requiring medication)

Medication	Dosage & Type (liquid, pill etc.)	Time of Day

Prescribing Dr. (name): ____________ Phone: __________ ☐ GP ☐ Neurologist ☐ Other: __________
Prescribing Dr. (name): ____________ Phone: __________ ☐ GP ☐ Neurologist ☐ Other: __________

I agree to release any indemnify and save harmless Epilepsy South Central Ontario and its employees from any and against all claims with respect to the costs, losses, damage or injury arising by reason of the administration of medication to my child as requested above.

______________________________ ______________________
Signature (Parent/Guardian) Date