



Family Centre Registration Form

Family Centre Empowers children and families through programs, resources, and connections. In accordance with the Freedom of Information Policy, and the Personal Information Protection Act, we are collecting this information for program, demographic, and reporting purposes. We will not pass on your personal information unless we are legally required to do so.

Does your family access Interfaith Foodbank? Yes No

Parent/Guardian/Caregiver Information (please print)

Legal First Name: Preferred Name: Legal Last Name:

Gender / Pronouns: Birthdate: DD/MM/YYYY Role in household (Parent, Grandparent, Child, etc)

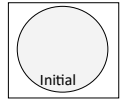
Address: City:

Postal Code: Home Phone: Cell Phone: Work Phone:

Email Address:

** We do not sell, rent, or lend our email list to anyone. You will receive only emails which are relevant to Family Centre and you may unsubscribe at any time. **

Background Information



For Office Use Only

In your daily life, are you safe and not at risk to be harmed? Yes No

Do you have a physical disability? Yes If you answered "yes", please provide details:

Do you have a developmental disability? Yes

Do you have special medical concerns? Yes

Do you identify as Indigenous? Yes Immigrant? Yes Refugee? Yes

Are you new to Canada? Yes How long have you been in Canada? Year(s)

In Case of Emergency

In case something happens to me while I am at Family Centre, please contact:

Name: Phone Number: Relationship:

If this is a spouse, please provide their birthdate for data purposes: DD/MM/YYYY

Disclaimer:

I have completed the registration form to participate in programming offered by Family Centre. I will respect the activities and property of Family Centre and I agree to leave the premises in the condition that I found them in. I understand that Family Centre will not be held responsible for any accident to me while on Family Centre premises.

Signature (Parent/Guardian): Date:

Please add additional family members on the reverse side of this page.

Legal First Name:	Preferred Name:	Legal Last Name:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Gender / Pronouns:	Birthdate: DD/MM/YYYY	Role in household (Parent, Grandparent, Child, etc)
<input type="text"/>	<input type="text"/>	<input type="text"/>
Do you have a physical disability?	Yes <input type="checkbox"/>	If you answered "yes", please provide details:
Do you have a developmental disability?	Yes <input type="checkbox"/>	<input type="text"/>
Do you have special medical concerns?	Yes <input type="checkbox"/>	
Do you identify as Indigenous? Yes <input type="checkbox"/>	Immigrant? Yes <input type="checkbox"/>	Refugee? Yes <input type="checkbox"/>
Are you new to Canada? Yes <input type="checkbox"/>	How long have you been in Canada?	<input type="text"/> Year(s)

Legal First Name:	Preferred Name:	Legal Last Name:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Gender / Pronouns:	Birthdate: DD/MM/YYYY	Role in household (Parent, Grandparent, Child, etc)
<input type="text"/>	<input type="text"/>	<input type="text"/>
Do you have a physical disability?	Yes <input type="checkbox"/>	If you answered "yes", please provide details:
Do you have a developmental disability?	Yes <input type="checkbox"/>	<input type="text"/>
Do you have special medical concerns?	Yes <input type="checkbox"/>	
Do you identify as Indigenous? Yes <input type="checkbox"/>	Immigrant? Yes <input type="checkbox"/>	Refugee? Yes <input type="checkbox"/>
Are you new to Canada? Yes <input type="checkbox"/>	How long have you been in Canada?	<input type="text"/> Year(s)

Legal First Name:	Preferred Name:	Legal Last Name:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Gender / Pronouns :	Birthdate: DD/MM/YYYY	Role in household (Parent, Grandparent, Child, etc)
<input type="text"/>	<input type="text"/>	<input type="text"/>
Do you have a physical disability?	Yes <input type="checkbox"/>	If you answered "yes", please provide details:
Do you have a developmental disability?	Yes <input type="checkbox"/>	<input type="text"/>
Do you have special medical concerns?	Yes <input type="checkbox"/>	
Do you identify as Indigenous? Yes <input type="checkbox"/>	Immigrant? Yes <input type="checkbox"/>	Refugee? Yes <input type="checkbox"/>
Are you new to Canada? Yes <input type="checkbox"/>	How long have you been in Canada?	<input type="text"/> Year(s)

Legal First Name:	Preferred Name:	Legal Last Name:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Gender/ Pronouns:	Birthdate: DD/MM/YYYY	Role in household (Parent, Grandparent, Child, etc)
<input type="text"/>	<input type="text"/>	<input type="text"/>
Do you have a physical disability?	Yes <input type="checkbox"/>	If you answered "yes", please provide details:
Do you have a developmental disability?	Yes <input type="checkbox"/>	<input type="text"/>
Do you have special medical concerns?	Yes <input type="checkbox"/>	
Do you identify as Indigenous? Yes <input type="checkbox"/>	Immigrant? Yes <input type="checkbox"/>	Refugee? Yes <input type="checkbox"/>
Are you new to Canada? Yes <input type="checkbox"/>	How long have you been in Canada?	<input type="text"/> Year(s)

Legal First Name:	Preferred Name:	Legal Last Name:
<input type="text"/>	<input type="text"/>	<input type="text"/>
Gender / Pronouns :	Birthdate: DD/MM/YYYY	Role in household (Parent, Grandparent, Child, etc)
<input type="text"/>	<input type="text"/>	<input type="text"/>
Do you have a physical disability?	Yes <input type="checkbox"/>	If you answered "yes", please provide details:
Do you have a developmental disability?	Yes <input type="checkbox"/>	<input type="text"/>
Do you have special medical concerns?	Yes <input type="checkbox"/>	
Do you identify as Indigenous? Yes <input type="checkbox"/>	Immigrant? Yes <input type="checkbox"/>	Refugee? Yes <input type="checkbox"/>
Are you new to Canada? Yes <input type="checkbox"/>	How long have you been in Canada?	<input type="text"/> Year(s)