

CWF Wrestling Camp

For Office Use Only

Date Received: _____

Time Received: _____

Please ensure all information is filled out
and all boxes are checked.

CHILD IDENTIFICATION

Full Legal Name: _____ Preferred Name: _____

Date of Birth (dd/mm/yyyy): _____ Age: _____

Home Address: _____

PARENT INFORMATION

Full Legal Name: _____ Primary Phone Number: _____

Cell Phone Number: _____ Email: _____

Full Legal Name: _____ Primary Phone Number: _____

Cell Phone Number: _____ Email: _____

EMERGENCY CONTACTS

In the event of an emergency, if a parent cannot be reached, the following individual(s) may be contacted in order of preference. **Be sure to include someone who will usually know your whereabouts.**

Emergency Contact #1	Emergency Contact #2	Emergency Contact #3
Full Legal Name: _____ Primary Phone Number: _____ <input type="checkbox"/> Authorized to pick up child	Full Legal Name: _____ Primary Phone Number: _____ <input type="checkbox"/> Authorized to pick up child	Full Legal Name: _____ Primary Phone Number: _____ <input type="checkbox"/> Authorized to pick up child

ADDITIONAL INFORMATION

Will your child be going home for lunch? ☐ Yes ☐ No
Will your child be staying for lunch? ☐ Yes ☐ No
Will your child be picked up after camp? ☐ Yes ☐ No
OR will your child be allowed to walk home? ☐ Yes ☐ No

HEALTH INFORMATION

Health Card Number (in case of emergency):

_____ - _____ - _____

Has your child ever experienced, been diagnosed with, or visited a medical professional for any of the following reasons:

Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do they require Puffers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other Seizure Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If yes, please explain: _____

Allergies? ☐ Yes ☐ No

If yes, please explain: _____

Does your child require an Epi-Pen? ☐ Yes ☐ No

If yes, is the Epi-Pen to be stored/carried? Where? _____

Recognizing Each Child's Uniqueness

We acknowledge that each child is unique. For instance, a child with visual impairments requires different supports than a child with behavioural challenges. This insight will guide us in customizing our approach to suit the individual needs of everyone. If needed, we may inquire further to ensure optimal accommodation for your child.

Does your child receive any additional assistance during the school year for any of the following:

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> ODD (Oppositional Defiant Disorder)
<input type="checkbox"/> Autism	<input type="checkbox"/> CD (Conduct Disorder)
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Other, please explain: _____

Recognizing Each Child's Uniqueness continued...

Does your child require support for educational needs, please explain: _____

Privacy of Personal Information collected in the 2025 Registration.

The personal information provided to us by you will be treated with a high level of confidentiality.

RISK/WAIVER AUTHORIZATION

While I agree to instruct my child to follow the safety instructions of the Nipissing First Nation/CWF Canada Wrestling Camp, I recognize and acknowledge that there is still a risk of injury.

I hereby give my consent to the following (please check each box):

☐ For my child to participate in the CWF camp activities.

☐ I understand and assume responsibility for all risks to my child in connection with their participation in activities. I understand there is a possibility of personal risk, damage, or injury.

☐ To waive, release and discharge Nipissing First Nation, its agents and employees from all liability to any individual, including my child.

☐ Further, I agree that the NFN Program Coordinator can administer medication that I have provided for my child. I accept the risks and agree that the above statement concerning waiver and release, apply to the administration of medication to my child. A copy of the prescription must be provided for instructions. (ONLY if provided by parents, by no means will any child be permitted to take medication without authorization.)

☐ I hereby acknowledge that my child's photographs may be used to update the community in the Nipissing First Nation Newsletter / Annual Report and may be used on social media such as NFN Facebook, twitter, etc.

Signature of Parent/Guardian:

Date:

Witness:

Date: