

September 20-22, 2024
Camp Papillon • 210 Papillon Street, Saint-Alphonse-Rodriguez, QC J0K 1W0



Dear Clients:

Find below our registration form for the 2024 Family Retreat. Registration forms are for all individuals residing in the same group. Please complete this form and return it no later than **Friday, August 23, 2024**. This information is being collected for the purposes of planning for the Quebec Family Retreat, and will be used to make the appropriate arrangements for that event. Muscular Dystrophy Canada will not share or distribute your personal information for any other purposes, without your consent. If you have questions or to send completed registration forms:

SEND TO:

Muscular Dystrophy Canada
Attention: Ivy Pierre-Louis
Phone: 1-800-567-2873 ext 3108
Email: ivy.pierre-louis@muscle.ca



CLIENT

First Name:

Last Name:

Street address:

City: Province: Postal Code:

Phone Number: Alternate Number:

Email Address:

EMERGENCY CONTACT:

Name (someone who is not travelling with you to the Retreat):

Home phone: Mobile phone:

Relationship to the emergency contact:

PERMISSIONS

I grant permission to Muscular Dystrophy Canada to photograph me during the Family Retreat and to use any photographs of me for Muscular Dystrophy Canada purposes, including education, awareness and marketing, in any media.

Yes

No

GUEST INFORMATION

Guest information, including client. Please include ages of participants:

			F	M	Non-binary/ Other
1. Name:	Age:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Power w/c	<input type="checkbox"/> Manual w/c			
2. Name:	Age:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Power w/c	<input type="checkbox"/> Manual w/c			
3. Name:	Age:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Power w/c	<input type="checkbox"/> Manual w/c			
4. Name:	Age:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Power w/c	<input type="checkbox"/> Manual w/c			
5. Name:	Age:		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Power w/c	<input type="checkbox"/> Manual w/c			

SPECIAL MEAL REQUIREMENTS

Vegetarian: # of people:

Life-threatening/serious allergies: # of people:

Other (specify): # of people:

Please indicate for which meal(s) you will be present for:

Saturday Breakfast Lunch Dinner **Sunday** Breakfast

REQUIRED ACCOMMODATIONS

Please indicate which night(s) you require accommodations for:

- Friday night
- Saturday night
- No overnight accommodation (attending Saturday day-time only)

