Intake Form Completed: Yes / No Paid: Yes/No Receipted: Yes/No

Cerebral Palsy Association in Alberta

Program:______________________________**Start/End Date:**____________________

Name: ________________________________ Date of Birth: ____________________

Address:________________________________ Postal Code:______________________

Phone (Days): ___________________ Phone (Evenings):_______________________

Emergency Contact Name: ____

Relationship: ____________________________ Phone (Days):_____________________

Phone (Evenings): ___________ Phone (Cell): ___________________________

Will Aide or Companion be accompanying member to the program: Yes / No

Name of Aide or Companion: ____

Name of Agency: ____

Phone (Cell): ______________________

Personal Information (for Emergency use only)

Alberta Health Care Number:__________________________

Doctor's Name: _______________________________

Medications currently prescribed and dosages: _________________________________

____

Are there any behavioral issues/problems that we should be aware of: Yes / No

If yes, what: ____

____

____

Any other information that would be of assistance to our staff or your client:___________

____

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