

To register by FAX or MAIL, complete this form & send it in.  
**Please call to confirm** that your registration has been received.

● FAX **250-338-8600**

### Main Contact Information

**Name:** \_\_\_\_\_ Birthdate: \_\_\_\_\_

BC Care Card #: \_\_\_\_\_ Allergies/Medical Conditions: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_

EMAIL \_\_\_\_\_ Family Doctor/phone #: \_\_\_\_\_

### Family Members

**Name:** \_\_\_\_\_ Birthdate: \_\_\_\_\_

BC Care Card #: \_\_\_\_\_ Allergies/Medical Conditions: \_\_\_\_\_

**Name:** \_\_\_\_\_ Birthdate: \_\_\_\_\_

BC Care Card #: \_\_\_\_\_ Allergies/Medical Conditions: \_\_\_\_\_

**Name:** \_\_\_\_\_ Birthdate: \_\_\_\_\_

BC Care Card #: \_\_\_\_\_ Allergies/Medical Conditions: \_\_\_\_\_

### Registration Information

**Participant's Name:** \_\_\_\_\_

Program: \_\_\_\_\_

Time: \_\_\_\_\_ Start Date: \_\_\_\_\_

Program Fee: \$ \_\_\_\_\_

**Participant's Name:** \_\_\_\_\_

Program: \_\_\_\_\_

Time: \_\_\_\_\_ Start Date: \_\_\_\_\_

Program Fee: \$ \_\_\_\_\_

**Participant's Name:** \_\_\_\_\_

Program: \_\_\_\_\_

Time: \_\_\_\_\_ Start Date: \_\_\_\_\_

Program Fee: \$ \_\_\_\_\_

**Participant's Name:** \_\_\_\_\_

Program: \_\_\_\_\_

Time: \_\_\_\_\_ Start Date: \_\_\_\_\_

Program Fee: \$ \_\_\_\_\_

**Total Fees:** \$ \_\_\_\_\_ + 5% GST (if over 14 yrs): \$ \_\_\_\_\_ = **TOTAL:** \$ \_\_\_\_\_

**Payment:** (Must be included with your registration)

( ) Cheque ( ) Visa ( ) MC

Credit Card #: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Cardholder's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_