BRAMPTON
Flower City
brampton.ca

QUESTIONS:
General Camp Inquiries at 3-1-1
ROP Child Care Subsidy Camp: 905-874-2313

REGISTRATIONS FOR ROP CHILD CARE SUBSIDY
Email registrations forms to
Ropchildcare@brampton.ca

A: FAMILY INFORMATION (participant's with medical ailments or special needs, also need to submit a *Participant Profile – Medical/Additional Information* form)

Do you have a City of Brampton Family Account?	YES NO	Has your address, phone number, or email changed?	YES NO
Are you a ROP Child Care recipient	YES NO		

ADULT'S LAST NAME	ADULT'S FIRST NAME	SEX (M / F)

ADDRESS	CITY	POSTAL CODE

HOME PHONE #	ALT PHONE #	EMAIL

EMERGENCY CONTACT LAST NAME	EMERGENCY CONTACT FIRST NAME	PHONE #	RELATIONSHIP

B: PARTICIPANT INFORMATION (birth date must be noted if under 18 years of age OR if participant wants to enroll in age specific programming)

LAST NAME	FIRST NAME	BIRTH DATE	SEX (M / F)
		mm / dd / yy	

Course Barcode	Course	Location	Date	Time	Course Fee	Extd. Day Care Fee	Fee
					$	$	$ 0.00
					$	$	$ 0.00
					$	$	$ 0.00
					$	$	$ 0.00
					$	$	$ 0.00
					$	$	$ 0.00
					$	$	$ 0.00
					$	$	$ 0.00
					$	$	$ 0.00

If busing is included in your program, please identify the following:	BUS ROUTE	BUS STOP

C: WAIVER

I agree to release, indemnify and save harmless the City from and against all claims, proceedings and/or actions in respect of any costs, losses, damage or injury arising by reason of my or the Dependant Registrants' participation in any activities offered by the City of Brampton's Community Services Department, or by reason of the provision of medical care by the City to me or the Dependant Registrants.

_____ _____

Adult/Parent/Guardian's Signature *Date*

D: PAYMENT

After you receive a confirmation email from the City of Brampton, you are responsible for paying any outstanding amount. Any outstanding amount will be noted in the email, and be visible on your City of Brampton online Family Account. Any ROP Child Care subsidy will automatically be applied to your account. You may pay this amount either by calling 3-1-1 or through the City's online registration system. Please note that a spot for camp is only confirmed once the outstanding amount is paid by the due date.

Date revised: 2020/06/26

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PERSONAL INFORMATION RECORD

PROGRAM NAME	COURSE CODE	START DATE

A. PARTICIPANT INFORMATION

NAME (LAST NAME, FIRST NAME)			ATTACH PHOTO HERE *(as required)*
PHONE # (XXX-XXX-XXXX)	DATE OF BIRTH (MM/YY/DD)	AGE:	
1. A) LEGAL PARENT/GUARDIAN NAME (LAST NAME, FIRST NAME)	B) LEGAL PARENT/GUARDIAN PHONE # (XXX-XXX-XXXX)		
2. A) LEGAL PARENT/GUARDIAN NAME (LAST NAME, FIRST NAME)	B) LEGAL PARENT/GUARDIAN PHONE # (XXX-XXX-XXXX)		

B. EMERGENCY CONTACT INFORMATION *(in the event parent/guardian cannot be reached. Must be 18 years of age or older)*

NAME (LAST NAME, FIRST NAME)	PHONE # (XXX-XXX-XXXX)
NAME (LAST NAME, FIRST NAME)	PHONE # (XXX-XXX-XXXX)

C. MEDICATION INFORMATION

1. DOES THE PARTICIPANT HAVE ANY ALLERGIES OR MEDICAL CONDITION(S)? ☐ YES ☐ NO

IF YES, PLEASE LIST HERE OR ENTER N/A:

2. DOES THE PARTICIPANT REQUIRE AN AUTO-INJECTOR? ☐ YES ☐ NO

3. DOES THE PARTICIPANT REQUIRE AN ASTHMA INHALER? ☐ YES ☐ NO

4. DOES THE PARTICIPANT REQUIRE MEDICATION TO BE ADMINISTERED BY STAFF? ☐ YES ☐ NO

5. PLEASE INDICATE IF THERE IS ANY OTHER INFORMATION ABOUT THE CAMP PARTICIPANT THAT STAFF SHOULD BE AWARE OF:

D. SUPPORT WORKER INFORMATION *(please complete the following where applicable)*

DOES THE PARTICIPANT RECEIVE SUPPORT AT SCHOOL?	☐ YES ☐ NO	
WILL THE PARTICIPANT BE ACCOMPANIED BY THEIR OWN PERSONAL SUPPORT WORKER?	☐ YES ☐ NO	*IF "YES", COMPLETE SECTION AND SEE NOTE BELOW*

SUPPORT WORKER NAME (LAST NAME, FIRST NAME)	**PHONE # (XXX-XXX-XXXX)**	**FILE # FOR VSC STAFF USE ONLY**

Please note: *Anyone attending as a personal support worker (including family member or friend), must be 16 years of age or older, provide a valid Vulnerable Sector Check (VSC) dated within 3 months, attend program regularly with participant (no additional worker allowed within same week of program), wear PPE, provide contact information and participate in daily health screening as applicable (individuals that do not pass screening will not be permitted to enter or attend).*

I, the undersigned, hereby:

- Certify that the information recorded above is accurate and complete.
- Authorize City of Brampton staff to administer the above-mentioned medication(s) to my child/dependent applicable to the timeframes and dosages identified.
- Acknowledge that any support workers I provide to assist the participant must be a minimum of 16 years of age and have a current and satisfactory Vulnerable Sector Police Record Check, to be presented to City of Brampton staff if requested.

_____ _____

Parent / Guardian Signature *Date (MM/DD/YY)*

Date revised: **June 21, 2024**

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MEDICATION ADMINISTRATION FORM

A. ADMINISTRATION INFORMATION

PROGRAM NAME	LOCATION
PARTICIPANT'S NAME (LAST NAME, FIRST NAME)	WEEK OF

NAME OF MEDICATION(S)	TIME MEDICATION IS TO BE ADMINISTERED	AMOUNT/DOSAGE TO BE ADMINISTERED

		MEDICATION NAME			
MONDAY	TIME				
	DOSAGE				
	ADMIN. BY				
	WITNESS BY				
TUESDAY	TIME				
	DOSAGE				
	ADMIN. BY				
	WITNESS BY				
WEDNESDAY	TIME				
	DOSAGE				
	ADMIN. BY				
	WITNESS BY				
THURSDAY	TIME				
	DOSAGE				
	ADMIN. BY				
	WITNESS BY				
FRIDAY	TIME				
	DOSAGE				
	ADMIN. BY				
	WITNESS BY				

Date revised: **June 21, 2024**