**Membership Form**

|  |
| --- |
| Personal Information |
| Full Name: |   |   |
|                                         Last | First |
| Address: |   |   |
|                                       Street Address | Apartment/Unit # |
|   |   |   |   |
|                                         City | Prov. | Postal Code |
| Home Phone: |   | Alternate Phone: |   |
| E-mail Address: |   |
| Are you a:Parent |   |
|                    Professional: |   |
|              Other: |   |
| Spouse’s Name: |   | Spouse’s Work Phone: |   |
|   |
| Child’s Information |
| Name: |   | School/Daycare: |   |
| Date of Birth: |   |      Grade: |   |
| Diagnosis: |   | Date Diagnosed: |   |
| Family Doctor: |   |        Phone: |   |
| Medicare Number: |   | Allergies/Medical Conditions |   |
| Any other pertinent information:   |
| How would you like us to contact you? |
| Phone: |   |   |
| E-mail: |   |   |
| Mail: |   |   |   |
|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |

\*\*\*\* The information collected in this form will solely be used by Upper Valley Autism Resource Centre Inc.  The information will not be given to any third-party.