**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.