Autism Atlantic Consulting Services
Girl Strong Summer Retreat – Weekend of Learning and Connecting
Acadia University, Wolfville NS
August 16-18, 2019

Name of participant: ____Age:_______________

Parent who will be attending with daughter:_______________________________________

Home Address: ____

Contact Information: (home)_______________________ (cell) _________________________

email:________________________________

Health Card #'s in case of emergency:

Parent:____

Daughter:____

Who to call in case of emergency: (number, name & relationship):

____

Medical concerns, allergies, mobility needs:

Parent: ____

Daughter: ____

Sensory sensitivities: ____

Other information that may be relevant: ____

____

1. Does you daughter know she has an autism diagnosis? ________
2. How old was she when she received her diagnosis? __________

Waiver: I (we) ____(print your name(s), parent(s)/guardian(s) of ____will not hold Autism Atlantic Consulting Services liable for any physical and/or psychological injuries/damages to ____ (daughter's name) incurred during the above sessions.

Signature(s): ____

Date: _________________________

Permission to use photos and/or video:

I (we) _______________________________________ give permission to Autism Atlantic Consulting Services to use pictures and/or videos taken during the sessions for use in future presentations and/or promotional materials.

Signature(s): ____

Date: _________________________