



Fraser Valley Aboriginal Children and Family Services Society

Sxwelmexwelh Sq'ep Registration (Gathering of Cultural Teachings)
Saturday, September 28, 2019 (8:30 am – 5:30 pm)

Location: Squiala Longhouse 45005 Squiala Road, Chilliwack

Primary Attendee Information (Please PRINT Clearly)

REGISTRATION NAME #1 (First & Last): EMAIL: RESIDENTIAL ADDRESS (STREET NUMBER, NAME, UNIT NUMBER, CITY/TOWN) PHONE NUMBER (PLEASE INDICATE TYPE OF PHONE): Is this a cell? OR a landline? YOUR AGE: BAND NAME YOU BELONG TO IF APPLICABLE: DO YOU LIVE ON OR OFF RESERVE: WHICH BEST DESCRIBES YOU (PLEASE SELECT ALL BOXES THAT APPLY TO YOU): HAVE YOU EVER ACCESSED XYOLHEMEYLH SERVICES? I PLAN ON ATTENDING (PLEASE SELECT ALL THAT APPLY): PLEASE LIST ANY ALLERGIES &/OR DIETARY RESTRICTIONS BELOW: EMERGENCY CONTACT INFORMATION (First & Last Name): RELATIONSHIP (Friend, parent, etc.): PHONE NUMBER:

Attendee #2 Information (Please PRINT Clearly)

REGISTRATION NAME #2 (First & Last): EMAIL: RESIDENTIAL ADDRESS (STREET NUMBER, NAME, UNIT NUMBER, CITY/TOWN) PHONE NUMBER (PLEASE INDICATE TYPE OF PHONE): Is this a cell? OR a landline? YOUR AGE: BAND NAME YOU BELONG TO IF APPLICABLE: DO YOU LIVE ON OR OFF RESERVE: WHICH BEST DESCRIBES YOU (PLEASE SELECT ALL BOXES THAT APPLY TO YOU): HAVE YOU EVER ACCESSED XYOLHEMEYLH SERVICES? PLEASE LIST ANY ALLERGIES, DIETARY RESTRICTIONS OR MEDICAL CONCERNS BELOW: EMERGENCY CONTACT INFORMATION (First & Last Name): RELATIONSHIP (Friend, parent, etc.): PHONE NUMBER:

Attendee #3 Information (Please PRINT Clearly)

REGISTRATION NAME #3 (First & Last): EMAIL: RESIDENTIAL ADDRESS (STREET NUMBER, NAME, UNIT NUMBER, CITY/TOWN) PHONE NUMBER (PLEASE INDICATE TYPE OF PHONE): Is this a cell? OR a landline? YOUR AGE: BAND NAME YOU BELONG TO IF APPLICABLE: DO YOU LIVE ON OR OFF RESERVE: WHICH BEST DESCRIBES YOU (PLEASE SELECT ALL BOXES THAT APPLY TO YOU): HAVE YOU EVER ACCESSED XYOLHEMEYLH SERVICES? I PLAN ON ATTENDING (PLEASE SELECT ALL THAT APPLY): PLEASE LIST ANY ALLERGIES, DIETARY RESTRICTIONS OR MEDICAL CONCERNS BELOW: EMERGENCY CONTACT INFORMATION (First & Last Name): RELATIONSHIP (Friend, parent, etc.): PHONE NUMBER:



Attendee #4 Information (Please PRINT Clearly)

REGISTRATION NAME #4 (First & Last):		EMAIL:
RESIDENTIAL ADDRESS (STREET NUMBER, NAME, UNIT NUMBER, CITY/TOWN)		PHONE NUMBER (PLEASE INDICATE TYPE OF PHONE): Is this a cell? <input type="checkbox"/> OR a landline? <input type="checkbox"/>
YOUR AGE: <input type="checkbox"/> Adult <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-12 <input type="checkbox"/> 13-15 <input type="checkbox"/> 16-18	BAND NAME YOU BELONG TO IF APPLICABLE:	DO YOU LIVE ON OR OFF RESERVE: <input type="checkbox"/> OFF <input type="checkbox"/> ON
WHICH BEST DESCRIBES YOU (PLEASE SELECT ALL BOXES THAT APPLY TO YOU): <input type="checkbox"/> Status <input type="checkbox"/> Non-Status <input type="checkbox"/> Métis <input type="checkbox"/> Inuit <input type="checkbox"/> Xyóheméylh Caregiver <input type="checkbox"/> Community Partner/Organization (please specify below):		
HAVE YOU EVER ACCESSED XYOLHEMEYLH SERVICES? <input type="checkbox"/> I am currently <input type="checkbox"/> I have previously <input type="checkbox"/> I have never received services from Xyóheméylh.		I PLAN ON ATTENDING (PLEASE SELECT ALL THAT APPLY): <input type="checkbox"/> Day #1 - FRIDAY <input type="checkbox"/> Day #2 - SATURDAY
PLEASE LIST ANY ALLERGIES, DIETARY RESTRICTIONS OR MEDICAL CONCERNS BELOW:		

Attendee #5 Information (Please PRINT Clearly)

REGISTRATION NAME #5 (First & Last):		EMAIL:
RESIDENTIAL ADDRESS (STREET NUMBER, NAME, UNIT NUMBER, CITY/TOWN)		PHONE NUMBER (PLEASE INDICATE TYPE OF PHONE): Is this a cell? <input type="checkbox"/> OR a landline? <input type="checkbox"/>
YOUR AGE: <input type="checkbox"/> Adult <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-12 <input type="checkbox"/> 13-15 <input type="checkbox"/> 16-18	BAND NAME YOU BELONG TO IF APPLICABLE:	DO YOU LIVE ON OR OFF RESERVE: <input type="checkbox"/> OFF <input type="checkbox"/> ON
WHICH BEST DESCRIBES YOU (PLEASE SELECT ALL BOXES THAT APPLY TO YOU): <input type="checkbox"/> Status <input type="checkbox"/> Non-Status <input type="checkbox"/> Métis <input type="checkbox"/> Inuit <input type="checkbox"/> Xyóheméylh Caregiver <input type="checkbox"/> Community Partner/Organization (please specify below):		
HAVE YOU EVER ACCESSED XYOLHEMEYLH SERVICES? <input type="checkbox"/> I am currently <input type="checkbox"/> I have previously <input type="checkbox"/> I have never received services from Xyóheméylh.		I PLAN ON ATTENDING (PLEASE SELECT ALL THAT APPLY): <input type="checkbox"/> Day #1 - FRIDAY <input type="checkbox"/> Day #2 - SATURDAY
PLEASE LIST ANY ALLERGIES, DIETARY RESTRICTIONS OR MEDICAL CONCERNS BELOW:		
EMERGENCY CONTACT INFORMATION (First & Last Name):	RELATIONSHIP (Friend, parent, etc.):	PHONE NUMBER:

Please Use Additional Registration Forms To Identify All Participants If Necessary

Please return your completed form on or before Mon. Sept. 16 to:

**Attention:
Norman Charlie**

Email: galisconsulting@gmail.com

or drop off at your local Xyóheméylh office:

<p>Langley 20644 Eastleigh Cres Ph: 604-533-8836 Fax: 604-533-8827</p>	<p>Abbotsford 2276 Clearbrook Rd Ph: 604-855-3328 Fax: 604-855-3329</p>	<p>Mission 3411- Lougheed Hwy Ph: 604-820-2595 Fax: 604-820-2597</p>	<p>Chilliwack 7201 Vedder Rd Ph: 604-858-0113 Fax: 604-824-5326</p>	<p>Agassiz 7278 Pioneer Ave Ph: 604-796-9836 Fax: 604-796-9837</p>
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