

## CHAMP Enrolment

**The information requested will assist us in providing resources specific to your child.** Please provide us with as much information as you can regarding your child's amputation to ensure our files are as complete and detailed as possible. **Information collected may be processed by a third-party service provider.**

### Information About Your Child

Child's name: \_\_\_\_\_  
First name Middle name(s) Last name

Child's preferred name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
day/month/year

Gender: \_\_\_\_\_ Child's preferred pronouns: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal code: \_\_\_\_\_

**For confidentiality and privacy purposes, all mail from the CHAMP Program will be mailed to your child at this address.**

Please state your language preference:  English  French

How did you learn about the CHAMP Program?

What are your most immediate needs?

How do you see CHAMP assisting you and your family?

### Information About the Parents/Guardians

**First parent/guardian:** \_\_\_\_\_  
First name Last name

Relationship to child: \_\_\_\_\_ Lives with child:  Yes  No Has legal custody:  Yes  No

Address (if different from child's): \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Ext.: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email: \_\_\_\_\_

**Second parent/guardian:** \_\_\_\_\_  
First name Last name

Relationship to child: \_\_\_\_\_ Lives with child:  Yes  No Has legal custody:  Yes  No

Address (if different from child's): \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Ext.: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email: \_\_\_\_\_

**We will require a copy of any custodial agreements in effect. In the absence of information, both parents will have equal access to the child's records.**

## Vendor Information

Please indicate the person(s) to whom The War Amps reimbursement cheques are to be made payable (i.e., travel expenses for prosthetic appointments, seminars, etc.).

First parent/guardian     Second parent/guardian     Both parents/guardians

## Type of Amputation(s)

Please select all amputation types that apply and indicate the location (for bilateral amputations, check both left and right). Provide the cause (at birth, medical or accident) and date of each amputation.

	Left	Right	Cause	Date
Transradial (below the elbow)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Partial hand	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Wrist disarticulation (through the wrist)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Transtibial (below the knee)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Transfemoral (above the knee)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Partial foot	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Syme's	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ankle disarticulation (through the ankle)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Knee disarticulation (through the knee)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Transhumeral (above the elbow)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Elbow disarticulation (through the elbow)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hemipelvectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Hip disarticulation (through the hip)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rotationplasty	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Forequarter	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Shoulder disarticulation (through the shoulder)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (please specify): _____				

The amputation(s) is/are the result of a limb length discrepancy of the:     Femur    and/or     Tibia/Fibula

The amputation(s) is/are the result of a limb length discrepancy of the:     Humerus    and/or     Radius/Ulna

The limb length discrepancy is:    \_\_\_\_\_ cm    or    \_\_\_\_\_ inches

Additional notes: \_\_\_\_\_

## Cause(s) of Amputation

Please select all that apply and provide the date(s) of each amputation or surgery, if applicable.

### At birth

- Congenital
- Congenital surgical  
(As a result of congenital limb deficiency where surgical amputation has been or will be required)
- Congenital type:
- No cause or diagnosis
- Amniotic band syndrome
- Fibular hemimelia
- PFFD
- TARS
- Other

Please specify: \_\_\_\_\_

### Medical

- Date of diagnosis: \_\_\_\_\_
- Cancer
- Meningitis
- Diabetes
- Vascular
- Sepsis
- Other
- Please specify: \_\_\_\_\_

### Accident

- Date of accident: \_\_\_\_\_
- Automobile accident
- Farm accident
- Lawn mower
- Train accident
- Electrocution
- Frostbite
- Grinder accident
- Workplace accident
- Miscellaneous accident
- Please specify: \_\_\_\_\_

Date(s) of amputation(s)/surgery or surgeries (if applicable): \_\_\_\_\_

Are you considering pursuing legal action as a result of the cause of amputation (if applicable)?  Yes  No

Please indicate the prosthetic/rehabilitation centre you attend: \_\_\_\_\_

Is a prosthetic limb/device currently being made?  Yes  No

## Other Sources of Funding

Are you eligible for funding from any other source, such as social assistance, or do you have personal extended health coverage or group insurance through your place of employment? This will ensure the coverage of artificial limbs is within our funding guidelines.

Yes *Please specify:* \_\_\_\_\_  No

## Release

In consideration of The War Amputations of Canada enrolling my child, \_\_\_\_\_, in the Child Amputee Program, known as the CHAMP Program, I, \_\_\_\_\_ (parent/guardian of \_\_\_\_\_), hereby release and forever discharge The War Amputations of Canada of any fault from all claims, demands, damages, actions or causes of action arising, or to arise, whatsoever in law or in equity which I, my heirs, executors, administrators or assigns can, shall or may have because of my child's involvement in the CHAMP Program, including activities such as video/film projects and other Association functions.

Further, I agree, accept and fully assume all risks of the possibility of personal injury, illness, death, property damage, or any loss or expense that may occur as a result of or arising out of my child, children's or my involvement in the CHAMP Program and related activities due to any cause whatsoever, and I agree to indemnify and save harmless The War Amputations of Canada and their successors and assigns against and from all actions, damages, debts, accounts, claims and demands that may hereafter be brought against them by or on behalf of my said child, myself or my other children because of their/our involvement with the CHAMP Program.

\_\_\_\_\_  
Parent/guardian (print name)

Email: \_\_\_\_\_

\_\_\_\_\_  
Witness (print name)

\_\_\_\_\_  
Parent/guardian's signature

Date: \_\_\_\_\_  
day/month/year

\_\_\_\_\_  
Witness' signature

Date: \_\_\_\_\_  
day/month/year

## Application Signatures

\_\_\_\_\_  
First parent/guardian's signature

Date: \_\_\_\_\_  
day/month/year

\_\_\_\_\_  
Second parent/guardian's signature

Date: \_\_\_\_\_  
day/month/year

## Consent to Release Information to a Third Party

I acknowledge that The War Amps may need to communicate personal information to a third party in order to provide requested services. Before or at the time The War Amps collects or accesses personal information, the Association will explain the information's intended use. Unless required by law, The War Amps will not use or disclose any personal information that has been collected without documenting the new purpose and obtaining further consent. A photocopy or electronic version of this authorization is as valid as the original. This permission is valid until I withdraw my consent in writing.

I/We authorize The War Amps to release my/our personal information relating to requested services such as accommodation, travel, shipping and special requirements to third parties.

\_\_\_\_\_  
First parent/guardian (print name)

\_\_\_\_\_  
Second parent/guardian (print name)

\_\_\_\_\_  
Relationship of first parent/guardian to child

\_\_\_\_\_  
Relationship of second parent/guardian to child

\_\_\_\_\_  
First parent/guardian's signature

\_\_\_\_\_  
Second parent/guardian's signature

Date: \_\_\_\_\_  
day/month/year

Date: \_\_\_\_\_  
day/month/year

**Please return your completed form to CHAMP.**

Charitable Registration No.: 13196 9628 RR0001