Holland Bloorview
Kids Rehabilitation Hospital

Youth Weekend Retreat Application

Section A – General Applicant Information

Last Name:	Initial:	First Name:

Address ***(#, Street, Unit #)*****:**

City/Town:	Province:	Postal Code:

Gender: ☐Male ☐Female	Date of Birth *(dd/mm/yy):*	Health Card Number:	Version Code:

Home Telephone: ( )	Cell Telephone: ( )

Section B – Emergency Contact Information

Emergency Contact Name:	Relationship to Applicant:

Address:

City/Town:	Province:	Postal Code:

Home Telephone: ( )	Cell Telephone: ( )
Other Telephone: ( )	**Other Telephone:** ( )

Additional Emergency Contact Information

Emergency Contact Name:	Relationship to Applicant:

Address:

City/Town:	Province:	Postal Code:

Home Telephone: ( )	Cell Telephone: ( )
Other Telephone: ( )	**Other Telephone:** ( )

Section C – Diagnosis information:

Code *(for office use only)* :

Detailed description of injury and/or disability:

Year of Injury (if applicable):

Please describe if there is anything else we should be aware of (i.e. learning disability, vision impairment, etc):

Please describe how your answer(s) above affect you physically (i.e. transfers, communication, etc) or cognitively (i.e. processing information, etc) :

Section D – Medical Information

Do you experience seizures: ☐Yes ☐No **If yes, please list date of last seizure:** (dd/mm/yy)

Frequency:

Type of seizure (please describe):

Intervention/how they are managed:

If more than standard first aid is required (ex. Medication administration), please include a specific seizure protocol from your Physician (form will be provided if required).

Do you have any allergies? ☐Yes ☐No
Please specify - food, environmental, substance, etc.

Intervention/how they are managed:

Are there any special considerations staff should be aware of? (i.e. do you have any practices specific to cultural beliefs; do you experience pain/discomfort; are there any foods you have difficulty eating; do you have anxiety in crowds, environments etc.?)

Section E – Medication

Do you take any medication? ☐Yes ☐No **(Please consider routine medication, emergency medication and as needed medication such as Tylenol or Gravol)** **If yes, please list below**	**Do you take your medication on your own?** ☐Yes ☐No **If no, please indicate the type of assistance required:** ☐ Remembering when to take ☐ Remembering how much to take ☐ Storing medication ☐ Opening containers ☐ Administering medication ☐ Other:__________________________________
Medication name: Reason for use: Dosage: Strength: Storage: Time given: Additional information:	Medication name: Reason for use: Dosage: Strength: Storage: Time given: Additional information:
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**if not enough space, please attach additional sheets with additional information*

NOTE: The Youth Weekend Retreat does not provide medical care such as dialysis treatments or insulin injections. It is a life skills and recreation service that provides attendant care services if required. Participants must be able to self-direct their own medication. If you have concerns, please speak with your lead staff.

Section E – Assistive Devices

Do you use an assistive device?: ☐Yes ☐No

IF YES, which of the following do you use?:
☐ Cane ☐Crutches ☐Walker ☐Braces/AFO's ☐Manual Wheelchair ☐Electric Wheelchair

IF YOU USE A WHEELCHAIR, are you able to walk to some extent with assistance?: ☐Yes ☐No

Section F – Risk of falls

Is there a history of illness-related falls? ☐Yes ☐No	**If yes, please explain:**
Are there any strategies in place to prevent the occurrence of falls? ☐Yes ☐No	**If yes, please explain:**

Section G – Activities of Daily Living and Personal Care Requirements

This section is very important in the planning of your care at the retreat.
Please make sure that you fully explain the how much assistance you require for each of the activities.

Task	Total Assistance (75-100%)	Some Assistance (25-75%)	No Assistance (0-25%)
Eating	☐	☐	☐
Additional information (if needed):			
Brushing teeth	☐	☐	☐
Washing hands/face	☐	☐	☐
Grooming (shaving)	☐	☐	☐
Dressing (upper body)	☐	☐	☐
Additional information (if needed):			
Dressing (lower body)	☐	☐	☐
Additional information (if needed):			
Showering / bathing	☐	☐	☐
Additional information (if needed):			
Toileting	☐	☐	☐
Additional information (if needed):			
Transferring: On & off the toilet	☐	☐	☐
In & out of the bathtub	☐	☐	☐
In & out of bed	☐	☐	☐
In & out of a wheelchair	☐	☐	☐

Section G (continued) – Activities of Daily Living and Personal Care Requirements

IF YOU NEED ASSISTANCE WITH TRANSFERRING, what is your preferred method:

☐Hoyer ☐2-person transfer ☐1-person transfer

Additional information (if needed):

Do you require:

Turning at night?	☐ Yes	☐ No	IF YES, how many times?:
A Hospital Bed?	☐ Yes	☐ No	
Do you use a G-Tube?	☐ Yes	☐ No	

Do you have control of your:	Do you use:	Night-time help required?	Do you require:	Do you use:
☐ Bowels	☐ Toilet	☐Yes ☐No	☐ Catheter irrigation	☐ Attends
☐ Bladder	☐ Commode chair	☐Yes ☐No	☐ Disempaction	☐ Condom drainage
☐ Neither	☐ Bed pan/ urinal	☐Yes ☐No	☐ Enemas ☐ Laxatives	☐ Colostomy
			☐ Suppositories	☐ Ileoconduit
				☐ Catheter: Type:

Section H – Communication

(a) Do you wear hearing aids? ☐Yes ☐No

(b) Do you have speech difficulties? ☐Yes ☐No

IF YES to (a) or (b) above, how do you communicate?:

☐ Verbal ☐ Bliss board, symbol or picture board ☐ Sign language ☐ Other (specify):

Section I – Social Development

Choose one of the following options below to describe your social interactions:

☐ I have no difficulties being in social situations.

☐ I may need support and encouragement when getting involved in new experiences.

☐ I am not comfortable socially. I need a lot of assistance with social situations.

Which one best describes your decision-making skills?

☐ Independent (no assistance necessary)

☐ Need some prompting

☐ Need total assistance

Which one best describes your ability to figure things out?

☐ I can clearly understand directions and respond correctly.

☐ Sometimes I need some direction and someone to explain more to me.

☐ I am usually confused by simple tasks.

Section J – Transportation

Transportation to and from the retreat is the responsibility of the participant.

Section K – Retreat Date and Program Fee

Retreat Date:
January 20, 2017 to January 22, 2017

Fee: $365 *(CHEQUE ONLY- made out to "**March of Dimes ABI Services"**)*
The program fee includes: accommodation and meals.

The full program fee **must** accompany this application form for the applicant to be considered for acceptance.

Section L: Verification and Signature

I verify that the information that has been given in this application is complete and accurate to the best of my knowledge. I agree to abide by the rules of the retreat and to conduct myself in a socially appropriate manner, and I understand that failure to so may result in my being asked to leave the retreat.

Consumer/Substitute Decision Maker Signature:	Date *(dd/mm/yy)*:

Please return this form by mail or to main reception:

Attn: Robyn Persaud
Holland Bloorview Kids Rehabilitation Hospital
Participation & Inclusion
150 Kilgour Rd.
Toronto, ON
M4G 1R8

Tel: (416) 425-6220 ext. 3296
Fax: 416-422-7037

Please note that submitting an application does not guarantee acceptance.
*The deadline for applications is Wednesday **October 26, 2016**.*