

**THERAPEUTIC RECREATION,  
LIFE SKILLS DEVELOPMENT AND TRANSITIONS  
2017 SUMMER PROGRAM APPLICATION**

<b>FOR OFFICE USE ONLY</b>			
<input type="checkbox"/> TRL.APLNW1 - FTF	<input type="checkbox"/> TRL.APLNW3 - FTF	<input type="checkbox"/> TRL.APLNW5 - FTF	<input type="checkbox"/> TRL.APLNW7 - FTF
<input type="checkbox"/> TRL.APLNW2 - NFTF	<input type="checkbox"/> TRL.APLNW4 - NFTF	<input type="checkbox"/> TRL.APLNW6 - NFTF	<input type="checkbox"/> TRL.APLNW8 - NFTF
<b>BOOKING NOTE:</b>			

**Please note that submitting an application does not guarantee acceptance. Individuals will be contacted to schedule an appointment for an interview. See summer brochure for details**

**PLEASE COMPLETE BOTH SIDES OF FORM**

**Section A – Application to programs**  
Check the box to indicate which program you would like to apply for. If you are interested in applying to more than one program, please indicate number 1<sup>st</sup> choice, 2<sup>nd</sup> choice and 3<sup>rd</sup> choice.

<b>Programs for children ages 7-14</b>	<b>Programs for youth ages 15-18 (up to 21 if still in high school)</b>
<input type="checkbox"/> Out & About Club <input type="checkbox"/> Fun with Friends <input type="checkbox"/> Busy Bodies <input type="checkbox"/> Camp Connection <input type="checkbox"/> Access Boom Sailing	<input type="checkbox"/> Making it Happen <input type="checkbox"/> Summer in the City <input type="checkbox"/> Youth@Work <input type="checkbox"/> The Independence Program (TIP) <input type="checkbox"/> Access Boom Sailing <input type="checkbox"/> Turning Point

**Have you participated in one of our programs before?**     No     Yes  
If yes, please write the names of the programs:

**Section B – General applicant information**

<b>Last name:</b>	<b>First name:</b>
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**Address (#, Street, Unit #):**

<b>City/Town:</b>	<b>Province:</b>	<b>Postal Code:</b>
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<b>Gender:</b>	<b>Telephone:</b> Please provide a number we can reach you during the day time or where we can leave a message.	Home # (    ) Cell # (    ) Work # (    )
<b>Date of birth: (dd/mm/yy)</b>		

**Client cell phone # (if applicable for ages 15-21):** (    )

<b>Health Card #:</b>	<b>Version Code:</b>
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**Section C – Description of disability/health condition**

Please describe your/your child's disability/health condition (diagnosis)

Do you have any other diagnoses?

- Hearing loss       Vision loss  
 Learning disability       Other (please specify)

Do you/your child require 1:1 assistance/supervision to participate in activities?  No  Yes

If yes, please explain the type and frequency of support required (please check all that apply):

- Medical support (eg. administering medications, injections, medical equipment like ventilators, etc.)  
 Behavioural support       Support for personal care       Other (please specify)

Please explain:

*Attendant care is provided in our group programs. Please note 1:1 support for medical or behavioural is **not** provided. If 1:1 support is needed, it is the participant's responsibility to schedule and pay for their own worker. We request 1:1 support be provided by a non-family member.*

**Section D – Communication**

How do you/your child communicate?

Alternate method (please specify)

Verbally

Symbol/picture board

Sign Language

Other (please specify)

Do you/your child need an interpreter to book and participate in an interview?  Yes  No

If yes, please identify language:

**Section E – Applications for Access Boom Sailing only**

Weight:

Height:

**Section F – Applications for youth (ages 15-18 up to 21 if in high school)**

Are you currently in school? Yes No      Current Grade:      Is this your last year?  Yes  No

What is the name of your school?

What stream are you in at school?

- Academic       Applied       Mix of academic/applied       Essential       Special education stream

**Section G - Verification and signature**

I verify that the information provided in this application is complete and accurate to the best of my knowledge

Applicant signature:

Date (dd/mm/yy):

The personal information you give us on this form helps us provide you with services at Holland Bloorview. We collect, use and share this information under the authority of the Public Hospitals Act. If you have questions, please contact the privacy office at 416-425-6220 ext. 3467 or [privacy@hollandbloorview.ca](mailto:privacy@hollandbloorview.ca).

**RETURN FORM TO: Holland Bloorview Kids Rehabilitation Hospital | Participation & Inclusion  
Attention: Heather Keating | 150 Kilgour Road, ON M4G 1R8  
Tel: 416.425.6220 x6208 | Fax: 416.422.7037**