



Section A – General Applicant Information

Last Name:	Initial:	First Name:
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Address (#, Street, Unit #):

City/Town:	Province:	Postal Code:
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Gender:	Date of Birth (dd/mm/yy):	Health Card Number:	Version Code:
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Home Telephone: ()	Cell Telephone: ()
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Section B – Emergency Contact Information

Emergency Contact Name:	Relationship to Applicant:
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Address:

City/Town:	Province:	Postal Code:
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Home Telephone: ()	Cell Telephone: ()
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Other Telephone: ()	Other Telephone: ()
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Additional Emergency Contact Information

Emergency Contact Name:	Relationship to Applicant:
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Address:

City/Town:	Province:	Postal Code:
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Home Telephone: ()	Cell Telephone: ()
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Other Telephone: ()	Other Telephone: ()
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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 InformationDo 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 Graval)

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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Reason for use:
Dosage:
Strength:
Storage:
Time given:
Additional information:

**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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional information (if needed):			
Brushing teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washing hands/face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming (shaving)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing (upper body)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional information (if needed):			
Dressing (lower body)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional information (if needed):			
Showering / bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional information (if needed):			
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional information (if needed):			
Transferring: On & off the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In & out of the bathtub	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In & out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In & out of a wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:
<input type="checkbox"/> Bowels <input type="checkbox"/> Bladder <input type="checkbox"/> Neither	<input type="checkbox"/> Toilet <input type="checkbox"/> Commode chair <input type="checkbox"/> Bed pan/ urinal	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Catheter irrigation <input type="checkbox"/> Disimpaction <input type="checkbox"/> Enemas <input type="checkbox"/> Laxatives <input type="checkbox"/> Suppositories	<input type="checkbox"/> Attends <input type="checkbox"/> Condom drainage <input type="checkbox"/> Colostomy <input type="checkbox"/> Ileoconduit <input type="checkbox"/> 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:**

Friday January 25th- Sunday January 27th, 2019.

Fee: \$365 (*CHEQUE ONLY please - made out to "March of Dimes Canada" with "Youth Weekend Retreat" in the memo line*)

The program fee includes: accommodation and meals.

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

Cheques may be postdated to December 18, 2017.

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 do 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: Kelsey Bell

Holland Bloorview Kids Rehabilitation Hospital

Transitions, Recreation and Life Skills

150 Kilgour Rd.

Toronto, ON

M4G 1R8

Tel: (416) 425-6220 ext. 3284

Fax: 416-422-7037

*Please note that submitting an application does not guarantee acceptance.
The deadline for applications is Wednesday **October 29, 2018.***