Holland Bloorview
Kids Rehabilitation Hospital

Registrant (Child) Name (please print: last, first): _____
FOR OFFICE USE ONLY: Date Received:_____Form #:____

Spiral Garden Summer 2024 Program Registration

We are pleased to offer Spiral Garden, an integrated outdoor art, play, music and garden program for all children. The program activities, site and staffing model are designed to be inclusive so all children can participate successfully. Support can be provided for a set number of children who need support around activities of daily living, medication routines, mobility and self-regulation.

1. Participants must be between 6 – 18 years of age.
2. The program will be offered in-person, on-site for two-week sessions*
3. Spiral Garden will be offering full-day programming from 9:00am – 4:00pm
4. For participant supports requiring an increased level of support:
    - Support will be provided by Holland Bloorview staff and/or volunteers, based on availability
    - Family-provided support may be accommodated, if possible.
    - Registration will happen on a first come first served basis. We will also a hold a limited number of spots for registrations received after April 1st that will be allocated by lottery on May 15th
    - Please note: clients who need *more than* one to one support may not be eligible for Spiral Garden
5. Registration is open to all children with and without disabilities or developmental delays.
6. Programming is designed to be outdoors and may be moved indoors based on extreme weather
7. All hospital recommended COVID-19 screening protocols and personal protective equipment will be implemented for staff and clients

Section A Registration for SPIRAL GARDEN program

Things to Know

- Participants must be 6-18 years old on or before December 31, 2024
- Registration is open to all children
- There are limited participant spots for children with higher support needs.
- After all interested participants receive one session, requests for a 2nd session will be considered. Please provide 4 choices. We will aim to offer you your first choice but this cannot be guaranteed.
- Participants will be assigned a session based on staffing levels and ability to accommodate participant needs.
- * One-week sessions may be available pending capacity. Please inquire about the one-week sessions.

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Please indicate the sessions that your child is able to attend; we will make every attempt to accommodate your first or second choice based on staffing and ability to support clients' needs.

Register for Spiral Garden:	**Summer 2024 Dates:**	**Preference** (Please indicate 1st, 2nd, 3rd and 4th choice)
☐ $625 Spiral Garden **Session A**	July 2-12 (9 days)	_____
☐ $695 Spiral Garden **Session B**	July 15 – July 26	_____
☐ $625 Spiral Garden **Session C**	August 6-16 (9 days)	_____
☐ $695 Spiral Garden **Session D**	August 19-30	_____

Section B Registrant (Child) Information*

First time applying to Spiral Garden? ☐ YES ☐ NO

First Name:		Last Name:	
Age:	Gender & Pronouns:	Birthdate (dd-mm-yyyy):	Healthcard #:

Family Physician Name & Phone #:

Has your child received other Holland Bloorview services?
☐ YES ☐ NO
If yes, where?: _____

Do you give consent for us to discuss how to maximize your child's participation in Spiral Garden with other Holland Bloorview teams? ☐ YES ☐ NO

Name of Clinician: _____
Contact Information:_____

Does your child receive clinical care outside of Holland Bloorview? ☐ YES ☐ NO
If yes, where? _____

Do you give consent for us to contact my child's external healthcare team in order to maximize their participation in Spiral Garden? ☐ YES ☐ NO

Name of clinician: _____
Contact Information:_____

☐ I understand that information disclosed about my child's healthcare will only be used to understand how Spiral Garden staff can best support my child's needs and maximize their participation during the program. I understand that Holland Bloorview collects, uses and shares this information under the authority of the Public Hospitals Act and Personal Health Information Protection Act (PHIPA).

Section C Family Contact Information

(1) Parent/Guardian Name:

Mailing address:		Email address:
City:	Province:	Postal Code:

Registrant (Child) Name (please print: last, first): _____

FOR OFFICE USE ONLY: Date Received:_____Form #:____

Home Phone:	Work Phone:	Cell Phone:
(2) Parent/Guardian Name:		
Mailing address:		Email address:
City:	Province:	Postal Code:
Home Phone:	Work Phone:	Cell Phone:
(3) Emergency Contact Name:		
Home phone:	Work phone:	Cell phone:

Section D Allergies and Medication

Does your child have any allergies?	☐ YES ☐ NO If yes, please specify:
If yes, what is the treatment for an allergic reaction?:	
Will your child have an EpiPen with them in the program?	☐ YES ☐ NO
Will your child be taking medication while in the program?	☐ YES ☐ NO
If yes, please describe the medication.	

Section E Support Needs Information

Please provide the following details to assist us in determining the level of support required for your child. Children who require staff support to participate successfully in this outdoor program will be provided a Holland Bloorview staff or volunteer, based on availability.

(1) What types of activities does your child like doing?	**What are some of their favourite things to do?**	**What are some of their routines for comfort:** *Favourite book, toy, song, active/quiet, tactile/sensory, other*

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(2) Diagnosis or Special Need(s):

(3) Mobility: Is your child at risk of falling? (eg. Fallen in the last three months as a result of diagnosis)
☐ YES ☐ NO

My child uses: ☐ support when walking ☐ a walker wheelchair: ☐ manual ☐ electric/power
☐ hand-over-hand assistance ☐ splints/orthotics – if YES, when?

My child needs an assistive device for lifts and transfers (eg. Hoyer lift, sling, etc.) ☐ YES ☐ NO

(4) Toileting:

Does your child need assistance with toileting? ☐ YES ☐ NO
If yes, please specify toileting routine details below (send slings and personal care items with your child)
Child's weight: _____lb / _____ kg

Bowel	Bladder	Requires	Uses
☐ Full control	☐ Full control	☐ Diapers/briefs:	☐ Toilet
☐ Occasionally incontinent	☐ Occasionally Incontinent	Size:_____	☐ Commode Chair
☐ Incontinent	☐ Incontinent	Type:_____	☐ Change Table
☐ Colostomy Bag	☐ Catheter routine	☐ Other:	
☐ Toilet Training	Type/size:_____	_____	
	Times: _____		
	☐ Drainage Condom _____		

(5) Eating:

Does your child need assistance eating? ☐ YES ☐ NO
If yes, please specify assistance needed below: *(Please send all food/equipment you child requires)*

☐ Regular texture ☐ Special: _____	☐ G-Tube ☐ NG Tube ☐ GJ Tube Tube size: _____ Type and amount of feeding/formula: _____	☐ Difficulty Chewing ☐ Difficulty Swallowing ☐ Bottle fed ☐ Total Parenteral Nutrition (TPN)	Other *(cultural/religious diet implications):*

Holland Bloorview
Kids Rehabilitation Hospital

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(6) Communication:

Does your child need assistance communicating? ☐ YES ☐ NO

My child communicates: ☐ verbally ☐ with gestures ☐ with sign language:

☐ with pictures ☐ with an assistive device/book:

(7) Behaviour/Coping Patterns: When in program, could your child?

☐ YES ☐ NO Get overwhelmed by loud/sudden noises?	Frequency: ☐Hourly ☐ Daily ☐Weekly ☐ Rarely
☐ YES ☐ NO Get overwhelmed by large groups of people?	☐Hourly ☐ Daily ☐Weekly ☐ Rarely
☐ YES ☐ NO Try to run away or leave the group/activity?	☐Hourly ☐ Daily ☐Weekly ☐ Rarely
☐ YES ☐ NO Harm themselves?	☐Hourly ☐ Daily ☐Weekly ☐ Rarely
☐ YES ☐ NO Harm others?	☐Hourly ☐ Daily ☐Weekly ☐ Rarely
☐ YES ☐ NO Participate without support?	☐Hourly ☐ Daily ☐Weekly ☐ Rarely
☐ YES ☐ NO Put non-food items in mouth that could be a choking hazard? (e.g., clay, paint, small objects, fabric etc.)	☐Hourly ☐ Daily ☐Weekly ☐ Rarely

Please describe your child's behavior where they might need staff support (e.g. trying to leave activity/area, harming themselves/others, etc.):

Please list any triggers for your child behaviours:

Please list any strategies that work to redirect your child and support them to regain self-regulation (re: specific sayings/language, certain activities, etc):

Have there been any recent and major changes in your child's life? If YES, please describe:

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Section F Seizures, Pain Management and Special Consideration

(1) Seizures: Does your child experience seizures? ☐ YES ☐ NO	Date of last seizure (dd-mm-yyyy):
What does a seizure look like (type, frequency, triggers, etc)?	
Will your child have seizure medication with them in the program? ☐ YES ☐ NO Does your child have a Vagal Nerve Stimulator (VNS)? ☐ YES ☐ NO	
(2) Pain: How will your child let us know they are experiencing pain?	
How can we help to alleviate this pain?	
(3) Other Considerations: My child uses/requires: ☐ helmet ☐ tip suctioning ☐ deep suctioning ☐ physical restraints (eg. Elbow splints, mitts) ☐ other (please describe:	
Does your child need an increased level of support to be safe and successful in this outdoor program? ☐ YES ☐ NO **If yes, do they need increased support** ☐ All the time ☐ Some of the time ☐ Rarely	
My child needs increased level of support for**:** ☐ toileting ☐ eating ☐ maintaining self-regulation ☐ mobility Please describe:	If a staff or volunteer supported spot cannot be provided, are you able to provide your own staff for the program? ☐ YES ☐ NO ☐ UNSURE

Holland Bloorview
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Section G Payment Information

Select a payment method in order for your registration form to be processed. Payment may be made by cash, cheque, credit card or funding/financial assistance. Please tell us below if you would like to pay in smaller payments. TOTAL AMOUNT: ____

I would like to pay by:

1. ☐ Funding – I have applied for funding from Holland Bloorview
2. ☐ Funding – I have applied for other funding
3. ☐ Cheque # _____ Cheque date _____
4. ☐ Cash $ amount_____
5. ☐ Credit Card: ☐ Mastercard ☐ Visa ☐ AMEX

Credit Card #	Expiry Date	Security Code:

Name on the card

Signature

☐ I consent for Holland Bloorview to file payment information for this season and understand that payment will only be stored for Spiral Garden 2024. I understand I will need to provide payment information for each seasonal application and that once payment has been processed, my payment information will be taken off file and destroyed.

☐ I do not consent for payment information to be provided with this application or kept on file and would like to be contacted via phone at the time of payment to provide credit card details.

Section H What happens next?

Submit your form using the information on the right. You will receive a confirmation and receipt via email, mail, or a phone call if more information or if Participant Screening Visit is required.

Registration closes: April 1st, 2024
Confirmations will be sent: no later than May 1st, 2024
Lottery for clients with disabilities that have applied after April 1st will occur: May 15th, 2024

Payments will be processed with your registration confirmation

If you are applying for funding, please apply for funding as soon as possible. Payment may be required prior to approval, in which case you funding would act as reimbursement

Please send your form to:

Holland Bloorview Kids
Rehabilitation Hospital
c/o Music and Arts

150 Kilgour Rd.
Toronto, ON M4G 1R8

Fax: (416) 753-6013

Section I How did you find out about us?

- ☐ My child has been in a Music and Arts program before
- ☐ From my child's heathcare provider
- ☐ From another parent/family ☐ From my child's school
- ☐ Online (Holland Bloorview website, Facebook, etc.)
- ☐ Other:

Contact Music and Arts:

Monday-Friday, 8:30am – 4:00pm

(416) 425-6220 ext. 3317

musicandart@hollandbloorview.ca