Holland Bloorview
Kids Rehabilitation Hospital

2021 Smart Centres Creative Arts March Break Respite Camp: March 15-19, 2021

Registration Package

Program eligibility

- Before you register your child for this program, a Respite Application Form must have been submitted within the last 12 months and your child's eligibility confirmed by the program coordinator. You can print the respite application form at http://www.hollandbloorview.ca/respite. For new applicants, you may be required to visit with the program team before your spot is confirmed.
- Children and youth 4-18 years old who have complex physical disabilities and developmental delays.
- Priority is given to children who require nursing support
- Child must be comfortable and be able to be successful in a group environment
- Maximum 1:1 support is available

Registering for the program

This package contains all the forms you need to complete. In order for your child's registration to be considered, ***the following items must be completed****, and received by the program team. As spaces fill quickly, we encourage you to submit these forms as soon as possible. Please note there are FIVE pages in the package.

- ☐ Registration Form (page 1) - this includes Bus Transportation and Payment information
- ☐ Care Plan Form, Medication Form, Anaphylaxis Individual Emergency Plan
- ☐ A photo of the registrant (please attach to the top-right of the Care Form) – small, wallet or passport-sized is fine
- ☐ Wheelchair Diagram Form (page 4)
- ☐ Consent for Release of Information (page 5) – ***this is an optional form***

* Incomplete packages will be held on a waitlist until all the above items have been received by the program team

Bus Transportation

You may apply for bus transportation between your home and the Camp each day of the program week, if you live in the City of Toronto. Let us know on page 1 of this package if you are interested. Please note that on Day 1 of the program, only in the morning, a parent/caregiver must come to the Hospital to sign in your child, even if they are coming on the bus.

3 ways to submit your completed registration package

1. Mail to: Holland Bloorview Kids Rehabilitation Hospital
   c/o Day Respite Services
   150 Kilgour Rd. Toronto, ON M4G 1R8
2. Fax to: (416) 753-6013
3. Drop off your completed package at the Main Reception desk

What happens next?

- After we receive your package, we will call you within 5 business days to confirm that it is received and complete
- Friday January 29, 2021: Payment processing begins
- Friday February 5, 2021: Welcome letters and receipt mail-out begins
- Tuesday February 23, 2021, between 5:30-9pm: Group Leaders will call families to introduce themselves and ask any questions
- Monday February 29, 2021, between 6 – 9 pm, as needed, the Nurse will make pre-admit calls.
- March 13-14, 2021: if you have selected bus transportation, the bus company, First Student, will confirm your child's pick-up and drop-off times
- March 15-19, 2021: March Break program week, parents must be present to sign their child in the morning of Day 1 of the program (March 15)

Contact the program office: Program Administrator, (416) 425.6220 ext. 3317

For office use Date received: _____ #: _____

Holland Bloorview
Kids Rehabilitation Hospital

2021 Registration Form

March Break 2021 ~ Monday to Friday ~ March 15 - 19, 2021 ~ 9:00am – 3:30pm

1. Registrant Information:

Child's name: _____ Child's date of birth: ____ / ____ / _____
dd mm yyyy

Parent's name: _____ Phone Number: _____

Cancellation Policy: Once your child's registration is confirmed, you must give notification *before Friday, February 12th* to cancel without a charge, otherwise the full program fee will apply.

2. Select the service(s) you would like:

I would like to register my child for the Camp ☐ $300.00

I would like to request Bus Transportation to/from Camp each day ☐ Yes - $75.00 or ☐ No

I need additional financial support to cover the cost of Bus Transportation ☐ Yes or ☐ No

3. ONLY for Bus Transportation requests:

Pick-up address (include postal code): _____

Drop-off address (include postal code): _____

1. My child will: ☐ walk onto the bus
   ☐ be in their wheelchair
   ☐ require a car seat/special seat

2. My child will: ☐ travel on the bus independently, OR
   ☐ be accompanied by a care provider or parent

3. On the bus, my child requires (e.g. harness, special chair, seat belt etc.): _____

4. Only on the morning of Day 1 (Monday, March 15th, 2021), we require a parent or caregiver to sign in each child in person.

   Please choose one: ☐ My child will come on the bus, and we/I will meet them at Camp, OR
   ☐ I will cancel the bus only for this morning and bring my child to Camp on March 15th, 2021

4. Payment Information:

Credit card: ☐ MasterCard ☐ VISA Card #:_____ Expiry: _____ Security Code: _____

Name on the credit card: _____ Signature: _____

Cheque: ☐ (attached) **Cash:** ☐ (enclosed) **Funding:** ☐ Holland Bloorview Family Support Funding ☐ Other

*** Cheques are payable to "Holland Bloorview" and can be post-dated to January 29, 2021*

5. Confirmation: You will be contacted within five (5) business days of receipt of this form to discuss your. Payment must be received in order to confirm your registration. Clients will be notified of their Credit cards will be charged after January 29, 2021. If you have any questions, please contact our Program Administrator at (416) 425-6220 ext. 3317. *Thank you!*

Holland Bloorview
Kids Rehabilitation Hospital

Attach PHOTO here
Please write name and birthdate on back.

Care Plan Form

Participant's name: _____ Date of Birth (dd/mm/yyyy): ____ /____ / _____

Parent/Guardian's name: _____

PLEASE READ CAREFULLY: Check this box if this entire page does not apply to your child: ☐ ~ OR ~ complete the sections on Medications and Allergies if they will be required for your child while they are in the program. If not, leave those sections blank. Only complete columns A, B, C and D.

A	B	C	D	Mon Mar 15	Tue Mar 16	Wed Mar 17	Thu Mar 18	Fri Mar 19
MEDICATION Please include strength (e.g. mg/ml etc.)	**Exact time to be given**	**Dosage & Details** (e.g. mg. to be taken with food, on an empty stomach etc.)	**Route** (e.g. via g-tube, orally etc.)	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial
1)				Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____
2)				Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____
3)				Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____

Medication must be…

1. sent in the amount required for the whole week
2. in the original childproof container;
3. not expired; and
4. bearing the pharmacy label and child's name.

A	B	C	D	Mon Mar 15	Tue Mar 16	Wed Mar 17	Thu Mar 18	Fri Mar 19
ALLERGIES Description (please include any known triggers)	**Treatment / EpiPen use / Medication**	**Dosage & Details** (e.g. mg. to be taken with food, on an empty stomach etc.)	**Route** (e.g. via g-tube, orally etc.)	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial
1)				Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____
2)				Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____
EpiPen included? ☐ Yes ☐ No ☐ n/a								

Declaration/Consent: I provide consent for the assigned RPN (Registered Practical Nurse) to administer medication and perform any other procedures or treatment, as directed above, to my child during the 2021 Creative Arts March Break Respite Camp at Holland Bloorview Kids Rehabilitation Hospital.

_____

Signature of Parent/Guardian **Date (dd/mm/yyyy)**

Holland Bloorview
Kids Rehabilitation Hospital

Attach PHOTO here
Please write name and birthdate on back.

Care Plan Form

Participant's name: _____ Date of Birth (dd/mm/yyyy): ____ /____ / _____

Parent/Guardian's name: _____

PLEASE READ CAREFULLY: Check this box if this entire page does not apply to your child: ☐ ~ OR ~ complete the sections on Seizures and Tube Feeding / Other Treatments if they will be required for your child while they are in the program. If not, leave those sections blank. Only complete columns A, B, C and D.

A	B	C	D	Mon Mar 15	Tue Mar 16	Wed Mar 17	Thu Mar 18	Fri Mar 19
SEIZURE PATTERN Description (include any known triggers and date of last seizure)	**Treatment / Medication**	**Dosage & Details** (e.g. mg. to be taken with food, on an empty stomach etc.)	**Route** (e.g. via g-tube, orally etc.)	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial
1)				Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____
2)				Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____
3)				Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____
Date of last seizure (dd/mm/yyyy): ____ / ____ / _____								

A	B	C	D	Mon Mar 15	Tue Mar 16	Wed Mar 17	Thu Mar 18	Fri Mar 19
TUBE FEEDING* / TREATMENT (e.g. catheterization, suctioning, etc.)	**Exact treatment time**	**Dosage & Details** (e.g. mg. to be taken with food, on an empty stomach etc.)	**Route** (e.g. via g-tube, orally etc.)	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial
1)				Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____
2)				Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____
3)				Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____
***Please send canned feed daily and provide one extra can as a backup.**								

Declaration/Consent:

I provide consent for the assigned RPN (Registered Practical Nurse) to administer medication and perform any other procedures or treatment, as directed above, to my child during the 2021 Smart Centres Creative Arts March Break Respite Camp at Holland Bloorview Kids Rehabilitation Hospital.

_____ _____

Signature of Parent/Guardian **Date (dd/mm/yyyy)**

Holland Bloorview
Kids Rehabilitation Hospital

☐ My child does not need this form.

Wheelchair Diagram Form

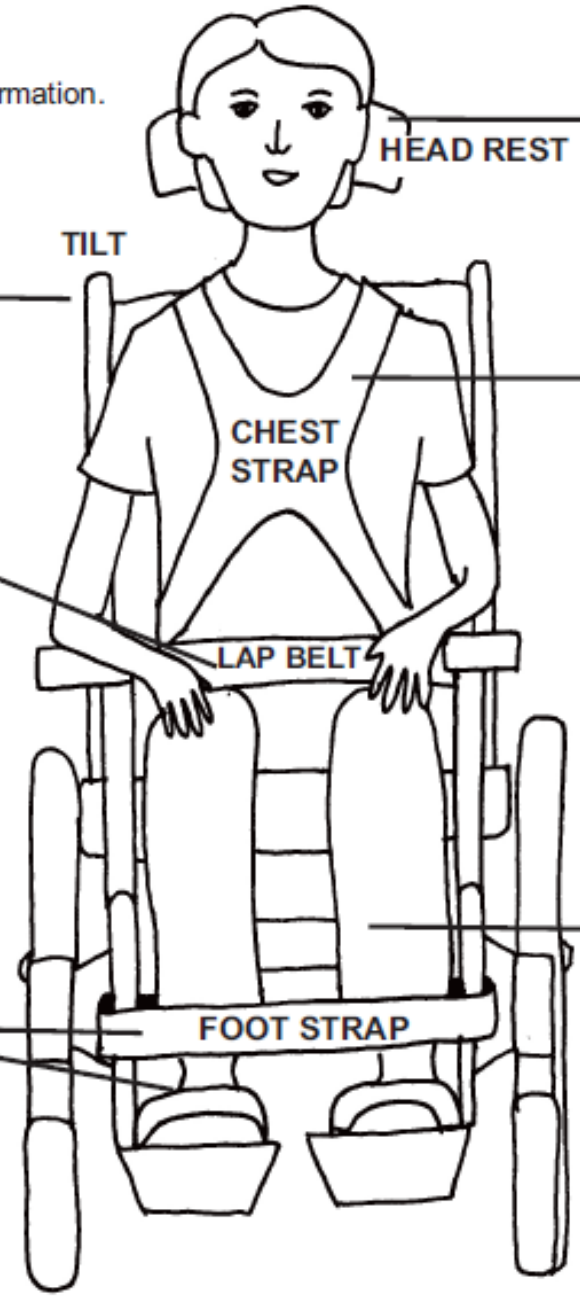
Wheelchair Usage: Belts, Straps, AFOs etc.

First name: _____

Please indicate when and how these are to be used, as applicable.

Draw any other relevant equipment as needed.

Include all pertinent information.



Please use **headrest**:
-describe:

Please use **tilt**:
-for transfers
-for comfort
-please detail:

Please use **chest strap**:
-always
-when travelling in vehicle
-when eating
-not applicable
-other:

Please use **lap belt:**
-always
-other

Please use **tray**:
-always
-for eating
-for activities
-not applicable
-other:

Please use **AFOs**:
-always
-when in walker
-not applicable
-other:

Please use **ankle/foot straps:** etc.:
-always
-behind feet
-in front of feet
-not applicable
-other:

Holland Bloorview
Kids Rehabilitation Hospital

Holland Bloorview
Kids Rehabilitation Hospital Foundation

See what a world without stigma looks like.

Consent for Release of Information by Holland Bloorview Kids Rehabilitation Hospital and Foundation

I give consent to Holland Bloorview and Holland Bloorview Foundation to release photographs, video, audio and voice clips, quotes, name, age and diagnosis of:

_____ _____ _____
Name of client/child | Age | Diagnosis (Optional)

For use in Hospital and/or Foundation promotional materials, publications and communications, for example; annual report, BLOOM, fundraising material, award submissions, Hospital and/or Foundation website, social media sites, and media stories (print, radio, television). Photos, videos and sound bites are stored in a protected photo bank.

PRIVACY: Holland Bloorview Kids Rehabilitation Hospital and Foundation take steps to protect your privacy. We do our best to prevent content from being used by others, however this is not always possible. The Hospital and/or Foundation cannot be held responsible for final text and images used in external media.

YOUR DECISION: It's your choice to take part. Your decision won't change the care you and your family receive at Holland Bloorview.

Name of person providing consent: _____ _____
Client, if over 18. If not, parent or guardian | Relationship to child

Signature: _____ **Date:** _____

Your Contact Information (for Holland Bloorview records only):

Name of consenting person: _____ _____
First Name | Last Name

Phone: (____) _____-_____ E-mail: _____

Address: _____
Street Address – No., Street, Apt

_____ _____ _____
City | Province | Postal Code

Please return this form to:
Holland Bloorview Kids Rehabilitation Hospital Foundation
For more information, please call (416) 424-3809.
Thank you!

FOR INTERNAL USE ONLY Date: _____ Consent expiry date: _____

Current project: _____ Staff member explaining consent: _____

_____

The personal information you give us on this form allows us to communicate to the public about our Hospital. We collect this information under the authority of the Public Hospitals Act. If you have any questions, please contact the privacy office at 416-425-6220 ext. 3467 or privacy@hollandbloorview.ca.
If at any time you wish to be removed from our contacts, please call us at 416-424-3809 or email foundation@hollandbloorview.ca

Effective April 2019

This is an optional form. ☐ I do not give this consent.