

Registrant (Child) Name (please print: last, first): \_\_\_\_\_

FOR OFFICE USE ONLY: Date Received: \_\_\_\_\_ Form #: \_\_\_\_\_

## Spiral Garden Summer 2022 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.

Once again, Spiral Garden is expected to be subject to the provincial guidelines for summer day camps, which are not yet available. Despite our best effort to predict what to expect for this summer, please note that the program details outlined below are conditional on the provincial guidelines that may result in modifications to the program structure and/or operations.

Additionally, there will be construction adjacent to Spiral Garden this summer. Please expect related construction noise, machinery and dust etc.

1. Registration is limited to clients ages 6 – 18 years
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. We provide a limited number of staff support spots. Participant support will be provided by Holland Bloorview staff and/or volunteers. Family-provided support will only be accommodated if possible when capacity limits are known.
5. Registration is open to all children with and without special needs. Should guidelines restrict our ability to operate at full capacity, there may be a set number of spots available for children with and without special needs.
6. Programming is designed to be outdoors and may be moved indoors based on extreme weather
7. All recommended COVID-19 screening protocols and personal protective equipment will be implemented for staff and clients

### Section A Registration for SPIRAL GARDEN program

July 5 – September 3 9:00am – 4:00pm

#### Things to Know

- Participants must be 6 years old on or before December 31, 2022
- Registration is open to all children, with options to provide participant support (re. staff/ volunteer assistance to participation)
- After all interested participants receive one session, requests for a 2<sup>nd</sup> session will be considered. Please provide 4 choices. We will aim to offer you your first choice but this cannot be guaranteed.
- Clients will be assigned a session based on staffing levels and ability to accommodate client needs.
- There is a set number of spots for participants requiring staff support.
- \*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.*

<b>Register for Spiral Garden:</b>	<b>Dates</b>	<b>Preference</b>
▶ <input type="checkbox"/> \$630 Spiral Garden Session A	July 11 - 22	_____
▶ <input type="checkbox"/> \$570 Spiral Garden Session B	July 25 – August 5 (9 days)	_____
▶ <input type="checkbox"/> \$630 Spiral Garden Session C	August 8 - 19	_____
▶ <input type="checkbox"/> \$630 Spiral Garden Session D	August 22 – September 2	_____

<b>Section B Registrant (Child) Information*</b>			
First Name:		Last Name:	
Age:	Gender:	Birthdate (dd-mm-yyyy):	Healthcard #:
Family Physician Name & Phone #:			

<b>Section C Family Contact Information</b>		
<b>(1) Parent/Guardian Name:</b>		
Mailing address:		Email address:
City:	Province:	Postal Code:
Home Phone:	Work Phone:	Cell Phone:
<b>(2) Parent/Guardian Name:</b>		
Mailing address:		Email address:
City:	Province:	Postal Code:
Home Phone:	Work Phone:	Cell Phone:
<b>(3) Emergency Contact Name:</b>		
Home phone:	Work phone:	Cell phone:

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<b>Section D Allergies and Medication</b>	
Does your child have any allergies?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, what is the treatment for an allergic reaction?	
My child will have an EpiPen with them in the program?	<input type="checkbox"/> YES <input type="checkbox"/> NO
My child will be taking medication while in the program?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, please describe the medication.	

<b>Section E Support Needs Information</b>
<p><b>Please provide the following details to assist us in determining the level of support required for your child.</b></p> <p>Children who require staff support to participate successfully in this outdoor program will be provided a Holland Bloorview staff or volunteer, based on availability.</p>
<p><b>(1) What types of activities</b> does your child like doing?</p> <p>What are some of their favourite things to do?</p> <p><b>What are some of their routines for comfort:</b> Favourite book, toy, song, active/quiet, tactile/sensory, other</p>
<p><b>(2) Diagnosis or Special Need(s):</b></p>
<p><b>(3) Mobility:</b> Is your child at risk of falling? (eg. Fallen in the last three months as a result of diagnosis) <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p>My child uses and/or needs: <input type="checkbox"/> support when walking <input type="checkbox"/> a walker <input type="checkbox"/> wheelchair: <input type="checkbox"/> manual <input type="checkbox"/> electric/power <input type="checkbox"/> hand-over-hand assistance <input type="checkbox"/> splints/orthotics – if YES, when?</p>
<p>My child needs an assistive device for lifts and transfers (eg. Hoyer lift, sling, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<p><b>(4) Toileting:</b> Does your child need assistance with toileting? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="text-align: right;">Child's weight: _____ lb / _____ kg</p>
<p>If yes, specify toileting routine details (send slings and personal care items with your child):</p>

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<b>(5) Eating:</b> Does your child need assistance eating? <input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, what type of assistance is needed? (please send all food/equipment your child requires)
<b>(6) Communication:</b> Does your child need assistance communication? <input type="checkbox"/> YES <input type="checkbox"/> NO
My child communicates: <input type="checkbox"/> verbally <input type="checkbox"/> with gestures <input type="checkbox"/> with sign language: <input type="checkbox"/> with pictures <input type="checkbox"/> with an assistive device/book:

<b>(7) Behaviour/Coping Patterns:</b> When in program, could your child?	
<input type="checkbox"/> YES <input type="checkbox"/> NO Get overwhelmed by loud/sudden noises?	<b>Frequency:</b> Hourly Daily Weekly Rarely
<input type="checkbox"/> YES <input type="checkbox"/> NO Harm themselves?	<b>Frequency:</b> Hourly Daily Weekly Rarely
<input type="checkbox"/> YES <input type="checkbox"/> NO Get overwhelmed by large groups of people?	<b>Frequency:</b> Hourly Daily Weekly Rarely
<input type="checkbox"/> YES <input type="checkbox"/> NO Harm others?	<b>Frequency:</b> Hourly Daily Weekly Rarely
<input type="checkbox"/> YES <input type="checkbox"/> NO Try to run away or leave the group/activity?	<b>Frequency:</b> Hourly Daily Weekly Rarely
<input type="checkbox"/> YES <input type="checkbox"/> NO Participate without support?	<b>Frequency:</b> Hourly Daily Weekly Rarely
<input type="checkbox"/> YES <input type="checkbox"/> NO <b>Put non-food items in mouth</b> that could be a choking hazard? e.g., clay, paint, small objects, fabric	<b>Frequency:</b> Hourly Daily Weekly Rarely
Please describe your child's behavior:	
Please list any triggers for your child behaviours:	

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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:

### 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

**(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:

G-tube feed       helmet       catheter       tip suctioning       deep suctioning  
 physical restraints (e.g.: elbow splints, mitts)       other (please describe):

**Does your child need one to one support to be safe and successful in this outdoor program?**

YES  NO

### 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: \_\_\_\_\_

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I would like to pay by:		
1. <input type="checkbox"/> Funding – I have applied for funding from Holland Bloorview		
2. <input type="checkbox"/> Funding – I have applied for other funding		
3. <input type="checkbox"/> Cheque # _____ Cheque date _____		
4. <input type="checkbox"/> Cash \$ amount _____		
5. <input type="checkbox"/> Credit Card: <input type="checkbox"/> Mastercard <input type="checkbox"/> VISA <input type="checkbox"/> AMEX		
Credit Card #	Expiry Date	Security Code
Name on the card		
Signature		

<b>Section H What happens next?</b>	
Submit your form using the information on the right. You will receive a confirmation and receipt in the mail, or a phone call if more information or if Participant Screening Visit is required.	<p><b>Please send your form to:</b></p> <p>Holland Bloorview Kids Rehabilitation Hospital</p> <p>c/o Music and Arts</p> <p>150 Kilgour Rd.</p> <p>Toronto, ON M4G 1R8</p> <p>Fax: (416) 753-6013</p>
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	

<b>Section I How did you find out about us?</b>	
<input type="checkbox"/> My child has been in a Music and Arts program before	<p><b>Contact Music and Arts:</b></p> <p>Monday-Friday, 8:30am – 4:00pm</p> <p>(416) 425-6220 ext. 3317</p> <p>musicandart@hollandbloorview.ca</p>
<input type="checkbox"/> From my child's healthcare provider	
<input type="checkbox"/> From another parent/family <input type="checkbox"/> From my child's school	
<input type="checkbox"/> Online (Holland Bloorview website, Facebook, etc.)	
<input type="checkbox"/> Other:	