Holland Bloorview
Kids Rehabilitation Hospital

# TRANSITIONS, RECREATION AND LIFE SKILLS DEVELOPMENT PROGRAM REGISTRATION

## Section A – Program Acceptance for:

| | |
|---|---|
| ☒ **Ages 7-14** | ☒ **Ages 15-18 (up to 21 if still in high school)** |
| **Group Name: _Active Together** | **Group Name: _____** |

## Section B – General Client Information

| **Last Name:** | **Initial:** | **First Name:** |
|---|---|---|
| | | |

**Parent/Guardian Telephone:** Please provide a number where we can reach parent/guardian

**Name:**

**Telephone:** ( ) ☐Home ☐Cell ☐ Work

**Telephone:** ( ) ☐Home ☐Cell ☐ Work

**Telephone:** ( ) ☐Home ☐Cell ☐ Work

**Does your child/youth have a cell phone**:
☐Yes ☐No If yes, please provide number

**Telephone:** ( )

**Name:**

**Telephone:** ( ) ☐Home ☐Cell ☐Work

**Telephone:** ( ) ☐Home ☐Cell ☐Work

**Telephone:** ( ) ☐Home ☐Cell ☐Work

**Client or Parent/Guardian email address:**

**Other Emergency Contact:**

**Name:** **Relationship:**

**Telephone:** ( ) ☐Home ☐Cell ☐Work

**Telephone:** ( ) ☐Home ☐Cell ☐Work

## Section C – Allergies

Do you / your child have any allergies? ☐Yes ☐No If YES, **please specify…**

| | |
|---|---|
| ☐ **Food:**<br>☐ **Environmental:**<br>☐ **Substance/Medication:**<br>☐ **Other:** | **How they are managed:** |

**Are there any special considerations staff should be aware of?** (i.e. do you / your child have any practices specific to cultural beliefs; do you /your child experience pain/discomfort; are there any foods you / your child have difficulty eating; do you / your child have anxiety in crowds, environments etc.?)

## Section D – Seizures

**Do you / your child 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:

## Section E – Assistive Devices

| | | |
|---|---|---|
| **Do you / your child use any mobility devices?** ☐ Yes ☐ No | **If yes, please indicate:** ☐ Manual wheelchair ☐ Scooter | ☐ Walker, type: _____ ☐ Power wheelchair ☐ Other, please specify |
| **If you use a wheelchair, how long can you tolerate being in the wheelchair?** | **If you use a wheelchair, are you independent with your mobility?** ☐ Yes ☐ No | |

**Do you use a different mobility device at home, school, in community?** ☐ Yes ☐ No
If yes, please describe.

| | |
|---|---|
| **Do you / your child use any other assistive devices or equipment?** (ex. Grab bar, reaching aid, etc.) ☐ Yes ☐ No | **If yes, please explain:** |

## Section F – Personal Care Assistance

**Do you require assistance with personal care? (using washroom, eating, dressing, catheterization etc.)**
☐ Yes ☐ No
If yes, describe:

| | **Approximate schedule (times of day) and length of time** | **Describe how assistance is provided at school and at home:** (What equipment/set-up? Who assists? What are the steps to assist?) |
|---|---|---|
| **Washroom** | | |
| **Eating** | | |
| **Dressing** | | |
| **Other** | | |

## Section G – 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:** |
| **Is there anything we should be aware of regarding a risk of falls for you / your child?** ☐ Yes ☐ No | **If yes, please explain:** |

## Section H – Communication

**What is you/your child's preferred method of communication?**

☐ Verbal ☐ Sign Language ☐ Symbol/picture board ☐ Alternate method (specify) _____

**Are there any strategies used at home/school (etc.) that we could apply to promote you/your child's communication?** If yes, please describe:

## Section I – 1:1 Support (for those who identified this in the interview)

**Was bringing your own 1:1 support discussed during the interview?** ☐Yes ☐No

**Have you confirmed the dates of the program with the 1:1 support worker?** ☐Yes ☐No

**Have you secured funding for the 1:1 support?** ☐Yes ☐No

## Section J: Identification for clients

**Our policies require that all participants provide a photograph, as well as a copy of the participant's health card. Please include on an additional sheet of paper and attach to this registration form.**

## Section K: 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.

| **Signature:** | **Date *(dd/mm/yy)*:** |
|---|---|

**Please return this form to:**
**Holland Bloorview Kids Rehabilitation Hospital | Transitions, Recreation & Life skills**
**Attention: Kristen English | 150 Kilgour Road, ON M4G 1R8**
**Tel: 416.425.6220 x3541 |**

*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.*