

2023 Creative Arts March Break Respite Camp:

March 13-17, 2023

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.
- **Limited number of 1:1 spots available for children who require this level of support. Children must be able to be successful in a 1 staff to 1 participant ratio.**
- **NEW: 1:1 spots, for both staff and volunteer placements, will be decided based on a lottery system**

Registering for the program

January 9 to February 1, 2023: program registration window is open.

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 SEVEN pages in the package.

- Registration Form (page 1) - this includes Bus Transportation and Payment information
- Care Plan Form, Anaphylaxis Individual Emergency Plan, Medication Form (page 2-5)
- 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 6)
- Consent for Release of Information (page 7) – **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

- Monday February 6, 2023: Welcome letters and receipt mail-out begins
- Tuesday Feb 21, 2023: between 5:30-9pm: Group Leaders will call families to introduce themselves and ask any questions
- Monday, Feb 27 2023, between 6 – 9 pm, as needed, the Nurse will make pre-admit calls
- Friday February 27, 2023: Payment processing begins
- March 10-12, 2022: if you have selected bus transportation, the bus company, First Student, will confirm your child's pick-up and drop-off times
- March 13-17, 2023: March Break program week, parents must be present to sign their child in the morning of Day 1 of the program (March 13)

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

For office use Date received: _____ #: _____

2023 Registration Form

March Break 2023 ~ Monday to Friday ~ March 13 - 17, 2023 ~ 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 noon on Friday, March 3rd, 2023* 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
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 13th, 2023), we require a parent or caregiver to be onsite 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 13th, 2023

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 March 11, 2023

*** Funding confirmations must be communicated by Friday, March 11, 2023

5. Confirmation: You will be contacted within five (5) business days of receipt of this form to discuss your registration. Payment must be received in order to confirm your registration. Clients will be notified if their Credit cards will be charged after March 10, 2023. If you have any questions, please contact our Program Administrator at (416) 425-6220 ext. 3317. *Thank you!*

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 Allergies and Seizure Pattern 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 13	Tue Mar 14	Wed Mar 15	Thu Mar 16	Fri Mar 17
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	Actual time given	Actual time given	Actual time given	Actual time given
				RPN signoff: 2 ID <input type="checkbox"/> Initial	RPN signoff: 2 ID <input type="checkbox"/> Initial	RPN signoff: 2 ID <input type="checkbox"/> Initial	RPN signoff: 2 ID <input type="checkbox"/> Initial	RPN signoff: 2 ID <input type="checkbox"/> Initial
1)				Time:	Time:	Time:	Time:	Time:
				2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____
2)				Time:	Time:	Time:	Time:	Time:
				2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____
EpiPen included? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a								

A	B	C	D	Mon Mar 13	Tue Mar 14	Wed Mar 15	Thu Mar 16	Fri Mar 17
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	Actual time given	Actual time given	Actual time given	Actual time given
				RPN signoff: 2 ID <input type="checkbox"/> Initial	RPN signoff: 2 ID <input type="checkbox"/> Initial	RPN signoff: 2 ID <input type="checkbox"/> Initial	RPN signoff: 2 ID <input type="checkbox"/> Initial	RPN signoff: 2 ID <input type="checkbox"/> Initial
1)				Time:	Time:	Time:	Time:	Time:
				2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____
2)				Time:	Time:	Time:	Time:	Time:
				2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____
3)				Time:	Time:	Time:	Time:	Time:
				2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____
Date of last seizure (dd/mm/yyyy): ____ / ____ / _____								

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 2023 Creative Arts March Break Respite Camp at Holland Bloorview Kids Rehabilitation Hospital.

Signature of Parent/Guardian

Date (dd/mm/yyyy)

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 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 13	Tue Mar 14	Wed Mar 15	Thu Mar 16	Fri Mar 17
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	Actual time given	Actual time given	Actual time given	Actual time given
				RPN signoff: 2 ID <input type="checkbox"/> Initial	RPN signoff: 2 ID <input type="checkbox"/> Initial	RPN signoff: 2 ID <input type="checkbox"/> Initial	RPN signoff: 2 ID <input type="checkbox"/> Initial	RPN signoff: 2 ID <input type="checkbox"/> Initial
1)				Time: _____	Time: _____	Time: _____	Time: _____	Time: _____
				2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____
2)				Time: _____	Time: _____	Time: _____	Time: _____	Time: _____
				2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____
3)				Time: _____	Time: _____	Time: _____	Time: _____	Time: _____
				2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____	2 ID <input type="checkbox"/> ____

***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 2023 Creative Arts March Break Respite Camp at Holland Bloorview Kids Rehabilitation Hospital.

Signature of Parent/Guardian

Date (dd/mm/yyyy)

My child does not need this form.

**Participation and Inclusion
Medication Form**

Participant Name: _____ Date of Birth: (dd/mm/yyyy) _____

Medication

Please consider routine medication, emergency medication and as needed medication such as Tylenol or Gravol, Asthma puffers, epi pen, complimentary/alternative remedies etc.

(Participant information)

Do you / your child take any medication? Yes No If **yes**, please list in the boxes below

Do you / your child take your medication on your own? Yes No

If **no**, please indicate the type of assistance required:

- Remembering when to take
- Storing medication
- Administering medication

- Remembering how much to take
- Opening containers
- Other: _____

Client Information provided by caregiver	
Medication Name	
Reason	
Dosage	
Strength	
Storage	
Time to be given	
Additional Information	
Medication Name	
Reason	
Dosage	
Strength	
Storage	
Time to be given	
Additional Information	

OFFICE USE ONLY Nurse changes made based on pre-admit call	
Medication Name	
Reason	
Dosage	
Strength	
Storage	
Time to be given	
Additional Information	
Medication Name	
Reason	
Dosage	
Strength	
Storage	
Time to be given	
Additional Information	

Caregiver Signature

Date

Nurse Signature

Date



Participation and Inclusion Medication Form

Participant Name: _____ Date of Birth: (dd/mn/yyyy) _____

Client Information provided by caregiver	
Medication Name	
Reason	
Dosage	
Strength	
Storage	
Time to be given	
Additional Information	
Medication Name	
Reason	
Dosage	
Strength	
Storage	
Time to be given	
Additional Information	
Medication Name	
Reason	
Dosage	
Strength	
Storage	
Time to be given	
Additional Information	

OFFICE USE ONLY Nurse changes made based on pre-admit call	
Medication Name	
Reason	
Dosage	
Strength	
Storage	
Time to be given	
Additional Information	
Medication Name	
Reason	
Dosage	
Strength	
Storage	
Time to be given	
Additional Information	
Medication Name	
Reason	
Dosage	
Strength	
Storage	
Time to be given	
Additional Information	

Caregiver Signature

Date

Nurse Signature

Date

If not enough space, please attach additional sheets with additional information



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.

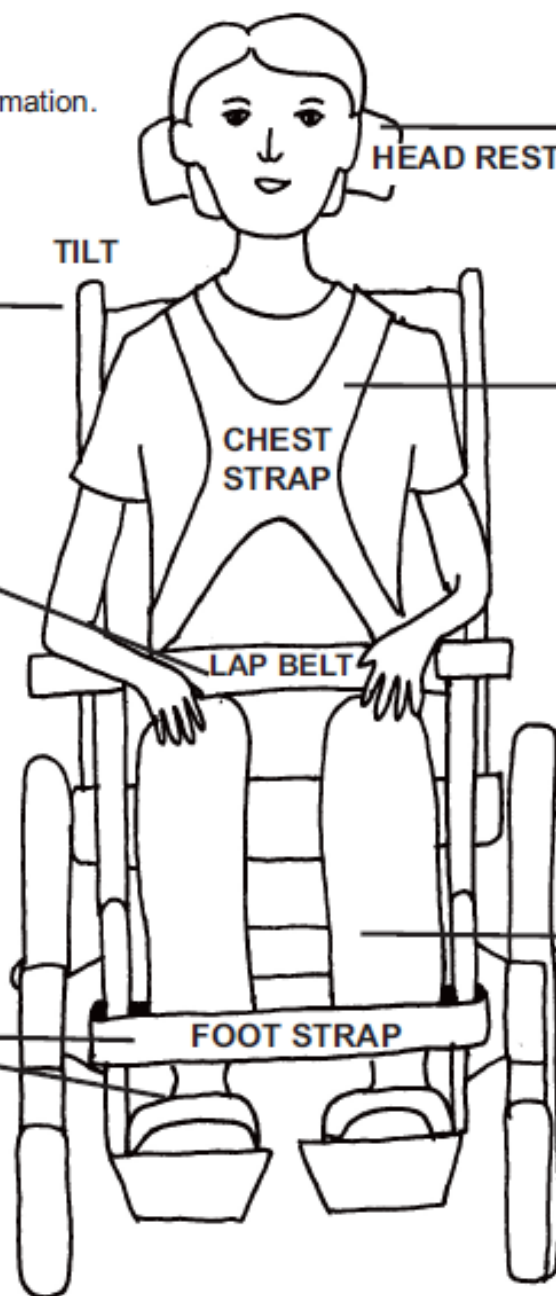
Include all pertinent information.

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

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

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

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



Please use **headrest**:
-describe:

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

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

Holland Bloorview

Kids Rehabilitation Hospital

Holland Bloorview

Kids Rehabilitation Hospital Foundation

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)
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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
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Signature: _____ Date: _____

Your Contact Information (for Holland Bloorview records only):

Name of consenting person: _____

First Name	Last Name
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Phone: (____) _____ - _____ E-mail: _____

Address: _____

Street Address – No., Street, Apt

City	Province	Postal Code
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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.