Heroes Circle Martial Arts 2024

Section A: General Applicant Information and Contact

Last Name:	**Initial:**	**First Name:**	
Preferred pronouns: She/Her He/Him They/Them	**Date of Birth *(mm/dd/yy):***	**Health Card Number:**	**Version Code:**

Parent/Caregiver Name:

Email address:

Telephone: ☐Home ☐Cell ☐Work
Telephone: ☐Home ☐Cell ☐Work

Emergency contact:
Name:
Relationship to the child:
Telephone: ( )
Telephone: ( ) ☐Home ☐Cell ☐Work

Section B – Health Information

Primary Diagnosis: **Secondary Diagnosis:**

Additional Comments:

Does your child experience seizures? ☐Yes ☐No **Date of late seizure:** DD/MM/YYYY:	**If yes, please describe:** **Type of seizure:** **Frequency:** **Intervention/how they are managed:**

Does your child have any allergies? ☐Yes ☐No
Please specify - food, environmental, substance, etc.

Section C: Risk of falls

Is there a history of illness-related falls? NONE ☐Yes ☐No	**If yes, please explain:**

Are there any strategies in place to prevent the occurrence of falls? ☐Yes ☐No	**If yes, please explain:**

Section D – Medication

Does your child take any medication? ☐Yes **(Please consider routine medication, emergency medication and as needed medication such as Tylenol or Gravol)**	**Will your child take medication during the session?** ☐No **If yes, please indicate the type of assistance required:**

Section E – Activity Participation

Does your child have any medical concerns that would make participation in physical activity risky?
☐Yes ☐No
If yes, please explain:

Are there any other safety considerations staff should be aware of? (i.e. experience pain/discomfort; tendency to wander, anxiety in crowds, environments; etc.?)

What are your goals/best hopes for participating in the Heroes Circle program?

Section F: 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.

Applicant Signature:	Date *(mm/dd/yy)*:
Parent/Guardian Signature:	Date *(mm/dd/yy)*:

Please return this form to:
Lindsey White | Holland Bloorview Kids Rehabilitation Hospital
Email: Lwhite@hollandbloorview.ca
Transitions, Recreation & Life Skills |
150 Kilgour Road, ON M4G 1R8 | Tel: 416.425.6220 ext.3541|