

Wheelchair Basketball Drop In 2024

General Applicant Information and Diagnosis

Last Name:		Initial:	First Name:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yy):		Health Card Number:	Version Code:

Email address: _____ **Telephone contact: Home:** _____
Cell: _____

Emergency contact:

Name:

Relationship to the child:

Telephone: () Home Cell Work
Telephone: () Home Cell Work

Primary Diagnosis: _____ **Secondary Diagnosis:** _____

Additional Comments: _____

Section C – Health Information

<p>Do you experience seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date of late seizure: DD/MM/YYYY:</p>	<p>If yes, please describe: Type of seizure:</p> <p>Frequency:</p> <p>Intervention/how they are managed:</p>
<p>Do you have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify - food, environmental, substance, etc.</p>	<p>Are there any special considerations staff should be aware of? (i.e. do you have any practices specific to cultural beliefs; do you experience pain/discomfort; are there any foods you have difficulty eating; tendency to wander, anxiety in crowds, environments; etc.?)</p>

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:

Section E – Medication

Do you take any medication?

Yes No

(Please consider routine medication, emergency medication and as needed medication such as Tylenol or Graval)

Do you take your medication during the session?

Yes No

If yes, please indicate the type of assistance required:

Section H – Activity Participation

Do you have any medical concerns that would make participation in physical activity risky? Yes No

If yes, please explain:

What are your goals/best hopes for participating in wheelchair basketball?

Section M: 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:

Holland Bloorview Kids Rehabilitation Hospital | Lindsey White
Participation & Inclusion, Therapeutic Recreation & Life Skills |
150 Kilgour Road, ON M4G 1R8 | Tel: 416.425.6220 ext.3541 | Fax: 416.422.7037

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.