Holland Bloorview
Kids Rehabilitation Hospital

2024 Creative Arts March Break Respite Camp:
March 11-15, 2024
Application 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 Staff/Volunteer-supported 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.**
- **1:1 spots, for both staff and volunteer placements, will be decided based on a lottery system**

Registering for the program

January 8 to February 1, 2024: 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)
☐ **IMPORTANT**: A photo of your child – small, wallet or passport-sized photo. Please attach to top right corner of form.
☐ Wheelchair Diagram Form (page 6)
☐ Consent for Release of Information (page 7) – ***It is your choice to participate. Your choice won't change the care you and your family receive from Holland Bloorview.***

***** 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 5, 2024: Welcome letters and receipt mail-out begins
- Wednesday Feb 21, 2024: between 5:30-9pm: Group Leaders will call families to introduce themselves and ask any questions, please be available to take this call
- Monday, Feb 26, 2024, between 6 – 9 pm, as needed, the Nurse will make pre-admit calls
- Friday March 1, 2024: Payment processing begins
- March 9 & 10, 2024: if you have selected bus transportation, the bus company, First Student, will confirm your child's pick-up and drop-off times
- March 11-15, 2024: March Break program week, parents must be present to sign their child in the morning of Day 1 of the program (March 11)

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

For office use Date received: _____ #: _____

2024 Registration Form

March Break 2024 ~ Monday to Friday ~ March 11-15, 2024 ~ 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 1st, 2024* 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 **OR** ☐ will be accompanied by a caregiver: Name:_____

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 11th, 2024), 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 11th, 2024

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 beginning March 1, 2024. If you have any questions, please contact our Program Administrator at (416) 425-6220 ext. 3317. *Thank you!*

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Care Plan Form

Attach PHOTO here
Please write name and birthdate on back.

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 11	Tue Mar 12	Wed Mar 13	Thu Mar 14	Fri Mar 15
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 ☐ Initial	RPN signoff: 2 ID □ Initial	RPN signoff: 2 ID □ Initial	RPN signoff: 2 ID □ Initial	RPN signoff: 2 ID □ Initial
1)				Time:	Time:	Time:	Time:	Time:
				2 ID ☐ ____	2 ID ☐ ____	2 ID ☐ ____	2 ID ☐ ____	2 ID ☐ ____
2)				Time:	Time:	Time:	Time:	Time:
				2 ID ☐ ____	2 ID ☐ ____	2 ID ☐ ____	2 ID ☐ ____	2 ID ☐ ____
EpiPen included? ☐ Yes ☐ No ☐ n/a								

A	B	C	D	Mon Mar 11	Tue Mar 12	Wed Mar 13	Thu Mar 14	Fri Mar 15
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 ☐ Initial	RPN signoff: 2 ID □ Initial	RPN signoff: 2 ID □ Initial	RPN signoff: 2 ID □ Initial	RPN signoff: 2 ID □ Initial
1)				Time:	Time:	Time:	Time:	Time:
				2 ID ☐ ____	2 ID ☐ ____	2 ID ☐ ____	2 ID ☐ ____	2 ID ☐ ____
2)				Time:	Time:	Time:	Time:	Time:
				2 ID ☐ ____	2 ID ☐ ____	2 ID ☐ ____	2 ID ☐ ____	2 ID ☐ ____
3)				Time:	Time:	Time:	Time:	Time:
				2 ID ☐ ____	2 ID ☐ ____	2 ID ☐ ____	2 ID ☐ ____	2 ID ☐ ____
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 2024 Creative Arts March Break Respite Camp at Holland Bloorview Kids Rehabilitation Hospital.

_____

Signature of Parent/Guardian **Date (dd/mm/yyyy)**

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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 11	Tue Mar 12	Wed Mar 13	Thu Mar 14	Fri Mar 15
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 RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial	Actual time given RPN signoff: 2 ID ☐ Initial
1)				Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____
2)				Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____
3)				Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____	Time: 2 ID ☐ ____

***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 2024 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.

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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

~REF MED PI~

Holland Bloorview
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Participation and Inclusion Medication Form

Participant Name: _____ **Date of Birth: (dd/mm/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	
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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

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☐ My child does not need this form.

Wheelchair Diagram Form

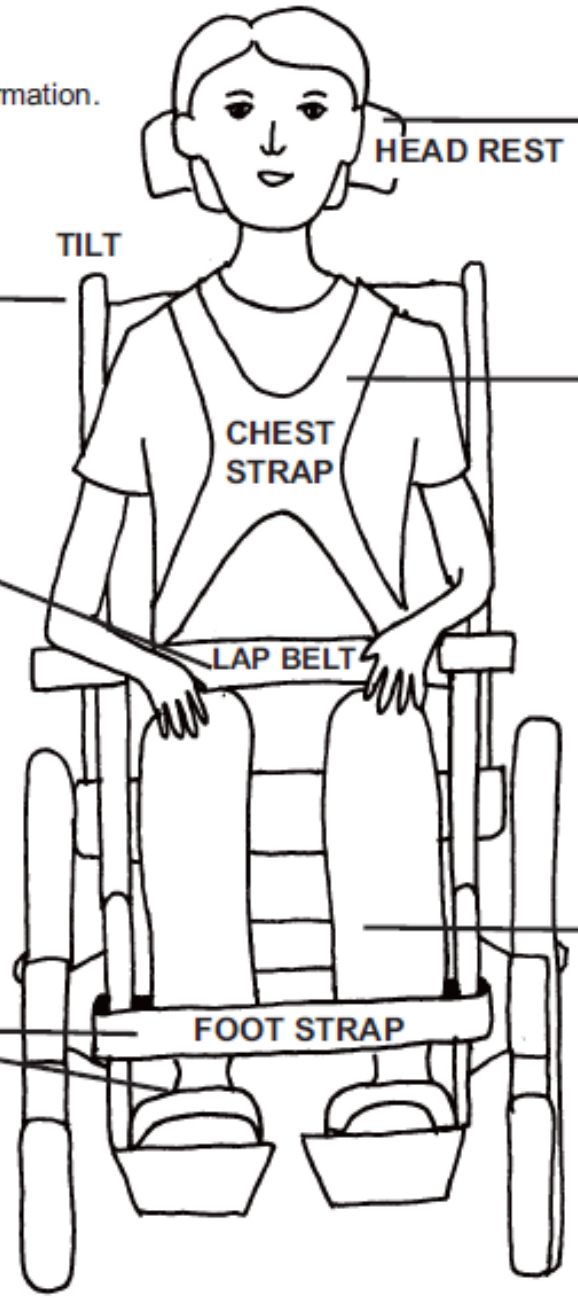
Wheelchair Usage: Belts, Straps, AFOs etc.

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 **headrest**:
-describe:

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

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

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

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

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

Please use **ankle/foot straps:** etc.:
-always
-behind feet
-in front of feet
-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) _____

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

Signature: _____ **Date:** _____

Your Contact Information (for Holland Bloorview records only):

Name of consenting person: _____ _____
First Name — Last Name

Phone: (____) _____-_____ E-mail: _____

Address: _____
Street Address – No., Street, Apt

_____ _____ _____
City — Province — Postal Code

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.