Holland Bloorview
Kids Rehabilitation Hospital

THERAPEUTIC RECREATION, LIFE SKILLS DEVELOPMENT AND TRANSITIONS AMBULATORY SOCCER - PROGRAM REGISTRATION

Section A – Program Registering for:

Novice (age 5-10) ☐ | **Intermediate (age 11-18)** ☐

Section B – General Client Information

Last Name:	**Initial:**	**First Name:**

Gender: ☐Male ☐Female	**Date of Birth *(dd/mm/yy):***	**Health Card Number:**	**Version Code:**

Client Telephone (ages 15-21):

Telephone: ( ) ☐Home ☐Cell ☐Work

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

Name:	**Name:**
Telephone: ( ) ☐Home ☐Cell ☐Work	**Telephone:** ( ) ☐Home ☐Cell ☐Work

Other Emergency Contact:

Name: **Relationship:**

Telephone: ( ) ☐Home ☐Cell ☐Work

Section C – Health Information

Please describe your / your child's disability:

Please describe if there is anything else we should be aware of (i.e. learning disability, vision impairment, etc):

Please describe how your answer(s) above affect you / your child physically (i.e. transfers, communication, etc) or cognitively (i.e. processing information, etc) :

Section D – Seizures

Do you / your child experience seizures? ☐**Yes** ☐**No** **If <u>yes</u>, please list date of last seizure:** (dd/mm/yy)

Frequency:

Type of seizure (please describe):

Intervention/how they are managed:

Section E – Allergies

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Do you / your child have any allergies? ☐Yes ☐No **Please specify - food, environmental, substance, etc.** **Intervention/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 F – 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 G – Medication

Do you / your child take any medication? ☐Yes ☐No **(Please consider routine medication, emergency medication and as needed medication such as Tylenol or Gravol, Asthma puffers, epi pen etc.)** **If yes, please list 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 ☐ Remembering how much to take ☐ Storing medication ☐ Opening containers ☐ Administering medication ☐ Other:_____

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**if not enough space, please attach additional sheets with additional information*

Section H – Assistive Devices

Do you / your child use any mobility devices? ☐Yes ☐No	**If yes, please explain:**
Do you / your child use any other assistive devices or equipment? ☐Yes ☐No	**If yes, please explain:**

Section I – Communication

Do(es) you / your child have speech difficulties? ☐Yes ☐No	**Do(es) you / your child wear hearing aids?** ☐Yes ☐No

If yes, how do you / your child communicate?
☐ **Verbal** ☐ **Symbol/picture board** ☐ **Sign Language** ☐ **Other (specify)**

If you / your child needs assistance, are you / your child able to describe what is needed? ☐Yes ☐No

Please explain:

Section J – Activity Participation

Do you / your child have any medical concerns that would make participation an any of the Soccer activites risky? ☐Yes ☐No	**If yes, please explain:**
Do you / your child need 1:1 assistance/ supervision in activities? ☐Yes ☐No	**If yes, please explain the type and frequency of support required:**

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Section K – Social Development

Choose one of the following options below to describe you / your child in social interactions:

☐ No difficulties functioning in social situations
☐ May need prompting and encouragement when getting involved in new experiences
☐ Poor socializing skills – needs complete supervision in social situations

Choose one of the following options below to describe your / your child's decision-making skills:

☐ Independent (no assistance necessary)
☐ Need moderate prompting
☐ Need total assistance

Choose one of the following options below to describe your / your child's cognitive reasoning skills:

☐ Clearly understand directions and respond accordingly
☐ Need some direction and further explanation at times
☐ Often experience confusion with comprehending minimal tasks

Section L: 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 | Attention: Kristen English
150 Kilgour Rd.
Toronto, ON
M4G 1R8

Tel: 416.425.6220 x3541 | Fax: 416.422.7037