

Recreation Services
**Participants With
Special Needs - Information**



PLEASE PRINT

Date: _____

Program / Camp: _____ Ratio of care requested: _____

Pool: _____

Personal Information

Participant Name: _____ Age: _____ Gender: M F

Address: _____

Postal Code: _____ Tel: _____

Name of Parent/Guardian: _____

Phone #: Home: _____ Cell: _____ Business: _____

E-mail: _____

Check box to receive email updates. You can unsubscribe at any time.

Participant Exceptionality

Diagnosis (Please provide detailed information of disability. Proof of diagnosis is required for participation in swimming):

Emergency Contact

1. Name: _____ Relationship: _____

Phone #: Home: _____ Cell: _____ Business: _____

2. Name: _____ Relationship: _____

Phone #: Home: _____ Cell: _____ Business: _____

3. Name: _____ Relationship: _____

Phone #: Home: _____ Cell: _____ Business: _____

Support Required

Which organization you are currently receiving support from?

Name: _____ Dates: _____

Contact Name: _____ Tel: _____

Type of Support: _____ Can we contact them if needed? Yes No

School Setting

N/A

Integrated

Non-Integrated

Integrated Part-Time

EA/CYW

Other Comments:

Is there a safety plan in place? Yes No

If yes, can we obtain a copy if necessary? Yes No

Behaviours exhibited:

Triggers for behaviours:

Outline Interaction with others (i.e. Group participation/interaction with own age group):

Fears / Anxieties:

Scheduling:

Other important information:

Medical Information

A. Medication / Auto-Injector / Health Concern:

Note: An Auto-Injector or Medication Form must be completed and signed by the parent/guardian before staff is able to assist in medication distribution. Staff are only permitted to do "hand-over-hand" administration of medication. Medication must be handed to staff at sign-in.

Child has medication to take during the day? Yes No

If 'yes', Medication Name:

How are they taken? Water Jam Other _____

Time of day to be taken: Before eating Lunchtime After eating Other _____

Any difficulties taking medication? Yes No

If 'yes', Please specify:

B. Seizures: Yes No

If 'yes', Type: _____ Controlled: _____

Frequency: _____ Duration: _____ Warning signs: _____

Preferred action taken: _____

C. Feeding & Eating Assistance:

Minimal assistance Medium assistance Full assistance

D. Allergies: Yes No

If 'yes', List: _____ Carries Epi Pen: Yes No

Other Information: _____

General Assistance

A. Recreational Activity Assistance:

Activities they participate in? 1. _____
2. _____
3. _____

Support required during activity: Yes No

If 'yes', assistive devices: _____

Inclusion techniques (i.e. change rules, equipment, outcome, etc.): _____

Staff / Leisure Buddy (explain): _____

B. Toileting Assistance:

Minimal assistance Medium assistance Full assistance Diapers Catheter

Other: _____

Comments: _____

C. Physical Mobility:

Needs assistance walking Needs assistance with a wheelchair Needs assistance with stairs

Other: _____

Please describe any difficulties s/he may have throughout his / her recreational activity: _____

D. Assistive Devices / Special Adaptations:

Please specify (i.e. glasses, helmet, wheelchair, prosthetic, etc.):

Communication

Select the most appropriate mode(s) of communication: Verbal Sign language PCS Gestural

How are the basic wants and needs expressed?

A. Expressive Communication:

Rate using the following scale: **N - Never** **S - Sometimes** **A - Always**

| | | |
|-------------------------------|-------------------------------|-----------------|
| ___ Communicates single words | ___ Spontaneous communication | ___ Echolalic |
| ___ Communicates phrases | ___ Ask Questions | ___ Perseverate |
| ___ Communicates single words | | |

Additional comments (i.e. participant responds to words, 'sit', not 'please sit down'):

B. Repetitive Communication:

Rate using the following scale: **N - Never** **S - Sometimes** **A - Always**

| | | |
|--|-----------------------------------|-------------------------------|
| ___ Comes when called by name | ___ Follow simple instructions | ___ Responds to sign language |
| ___ Answers questions | ___ Follow complex instructions | ___ Responds to PCS |
| ___ Stop activity in response to, 'No' or 'Stop' | ___ Responds to written direction | |

How does the person react when this communication is unsuccessful or not understood?

Behaviour

Please provide suggestions to deal with specific behaviour.

Rate using the following scale: **0 - No** **1 - Less than once/week** **2 - Less than once/day** **3 - More than once/day**

| | | |
|-------------------------|---------------------------|----------------------------|
| ___ Resistant to change | ___ Temper tantrums | ___ Sexual appropriateness |
| ___ Hyperactive | ___ *Self-injurious | ___ Profane language |
| ___ Crying / whining | ___ *Aggressive to others | |

*Please describe participant's self injurious and aggressive behaviours:

Please describe participant' behaviour when he/she:

- Can't make self understood: _____
- Is denied a request: _____
- Is in a new environment: _____
- Is in a noisy environment: _____

Please list all antecedents to behavioural problems:

Describe effective methods of dealing with inappropriate behaviour:

Swimming

Doctor consent for swimming: Yes No

Attach proof of diagnosis or doctor's certificate that the child has a disability and 1:1 swimming instruction is recommended.

Proof of diagnosis or doctor's certificate attached: Yes No

A. Swimming Experience:

Has the person had swimming lessons before? Yes No

Can the participant swim? (2 widths of the pool and tread water for 1 minute) Yes No

If 'yes', please bring previous report card, indicating level, to the instructor on the first day. Last completed level: _____

B: Swimming Assistance:

Minimal assistance Medium assistance Full assistance

Comments: _____

Please explain how the disability will affect the person in the water:

Participant goals (Note: 1:1 swimming lessons will be lead through skill based activities focusing on an individualized approach):

C: Mobility:

Minimal assistance Medium assistance Full assistance Splints Walker Wheelchair

Other: _____

Please describe any difficulties he/she may have throughout his/her lessons: _____

Notes the to the instructor that would be helpful in teaching the participant: _____

PLEASE NOTE: A doctor’s note is required prior to registering for any special needs swimming lessons. Proof of diagnosis or doctor’s note attached. Doctor’s note must specify that the child has a disability and 1:1 swimming instruction is recommended.

Please return this information form to the program coordinator **before the first lesson**. If there are any changes to the above information, advise the coordinator immediately. **The Inclusion & Community Services Specialist may be reached at 905.832.2377 ext.7405 or specialneeds@vaughan.ca.**

Special Needs Information Forms must be updated every two (2) years for children 3-12 years old and four (4) years for children 13+ years old.

I verify the above information to be correct to the best of my knowledge.

Signature of Parent/Guardian _____ Date: _____

Authorization

Personal information on this form is collected pursuant to the Municipal Act, 2001, S.O. 2001 c.25, as amended. It will be used to process your registration form, collect fees, assign participants to various programs, adapt the program based on individual needs, and record any medical information (if required). Questions about this collection should be directed to the Recreation Coordinator for Special Needs/Volunteers, City of Vaughan, 2141 Major Mackenzie Drive, Vaughan, Ontario L6A 1T1, at 905.832.8500.

Permission is hereby granted to Recreation Services or its representative to transport my child/ren to a local doctor or hospital for medical treatment if necessary. I agree to release, discharge, to indemnify and save harmless the City of Vaughan form and against all claims or proceedings in respect of any costs, losses, damage, or injury. By registering in a program I agree to medical attention and accept inherent risks associated with the program.

Signature of Parent/Guardian _____ Date: _____

Office Use Only:

Staff Comments: _____

Staff Name: _____ Date: _____