

# Participant with a Disability Information



Please print clearly if completing paper copy.

Date: \_\_\_\_\_

Program / Camp: \_\_\_\_\_

Ratio of care requested: \_\_\_\_\_

Pool: \_\_\_\_\_

## Personal Information

Participant Name: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M ☐ F ☐ Other ☐

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Phone #: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Other: \_\_\_\_\_

E-mail: \_\_\_\_\_

Email address is mandatory as this will be the primary method of communication.

**Participant Disability** Yes ☐ No ☐

Please provide detailed information of the functional limitation. Doctor's note stating that a disability exist is required for participation in swimming.

## Emergency Contact

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Other: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Other: \_\_\_\_\_

3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Other: \_\_\_\_\_

## Support Required

Which organization you are currently receiving support from?

Name: \_\_\_\_\_ Dates: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

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:

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Is there a safety plan in place? Yes ☐ No ☐

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

Behaviours exhibited:

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Triggers for behaviours:

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

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Fears / Anxieties:

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Scheduling:

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Other important information:

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## 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:

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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:

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**B. Seizures:** Yes ☐ No ☐

If 'yes', Type:

Controlled:

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Frequency:

Duration:

Warning signs:

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Preferred action taken:

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**C. Feeding & Eating Assistance:**Minimal assistance ☐Medium assistance ☐Full assistance ☐**D. Allergies:** Yes ☐No ☐

If 'yes', List: \_\_\_\_\_

Carries Epipen: Yes ☐No ☐

Other Information:

**Accommodations Required****A. Recreational Activity Assistance:**

Activities they participate in? 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Support required during activity: Yes ☐No ☐Inclusion techniques (i.e. change rules, equipment, outcome, etc.):  
\_\_\_\_\_  
\_\_\_\_\_Staff / Volunteer (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 / 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

\_\_\_ Asks questions

\_\_\_ Perseverate

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

\_\_\_ Follows simple instructions

\_\_\_ Responds to sign language

\_\_\_ Answers questions

\_\_\_ Follows 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's 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 ☐

Provide a doctor's certificate that your child has a disability and one-on-one swimming is recommended.

Doctor's note or 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 to the instructor that would be helpful in teaching the participant:

**PLEASE NOTE:** Provide a doctor's certificate that your child has a disability and one-on-one swimming 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 [specialneeds@vaughan.ca](mailto: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**

*I agree that by registering for this City of Vaughan Program, I will be bound by all of the terms and conditions of the City with respect to such programs, including those contained in the **COVID-19 Acknowledgement, Release and Indemnity Agreement** (the "Agreement") found below. I agree to review the content of the Agreement prior to registering in any program, in particular with respect to provisions intended to control the spread of the COVID-19 pandemic and penalties for non-compliance with all City provisions. I agree that if I do not consent to any of its terms or conditions I will not register for any City of Vaughan programs.*

*I also hereby grant permission to the City of Vaughan or its representative to contact 911 in order to make arrangements for the transportation of any registrants named on this form to a local doctor or hospital for medical treatment if deemed necessary by the City. I hereby release and discharge, and agree to indemnify and save harmless the City of Vaughan from and against all claims or proceedings in respect of any costs/losses incurred, and damage/injury experienced as a result of, or arising out of my/our registration and/or attendance in this program. By registering in this program I agree to having any required emergency and/or medical procedures administered to any registrants. On behalf of all registrants, I accept all inherent risks associated with the program, whatever they may be.*

*This form may contain personal information as defined under the Municipal Freedom of Information and Protection of Privacy Act. This information is collected under the legal authority of the Municipal Act, 201, S.O. 2001 c.25, as amended. This information will be used by the City of Vaughan and will become a part of Recreation Services files, where applicable. Questions regarding this collection may be directed to the Director of Recreation Services, City of Vaughan, 2141 Major Mackenzie Drive, Vaughan, Ontario L6A 1T1, 905.832.8500.*

Signature of Parent/Guardian \_\_\_\_\_

Date: \_\_\_\_\_

**Office Use Only:**

Staff Comments:

Staff Name: \_\_\_\_\_

Date: \_\_\_\_\_