MAIN STREET
Community Services

Discovered Treasures ~ Summer Camp Registration Form
July 3rd- August 30th, 2019

PLEASE ATTACH CURRENT PHOTO OF YOUR CHILD

Program Requested: _____Summer Camp_____ **Date:** _____

Client's Information:

Client's Name: _____ **Date of Birth**: _____

Address: _____ **Phone #:** _____

_____ **Postal Code:** _____

Ethnicity: _____ **Religion:** _____

Client's OHIP #: _____ **Copy of OHIP on file:**

Family Doctor: _____ **Phone #:** _____

Other Doctor: _____ **Phone #:** _____

Other Doctor: _____ **Phone #:** _____

Diagnoses: _____

Physical Description of the Client:

Height: _____ **Weight:** _____ **Build:** _____

Hair Colour: _____ **Length:** _____ **Style:** _____

Eye Colour: _____ **Glasses or contacts:** _____

Scars or Birthmarks: _____

Parent/Guardian Information:

Parent(s')/Guardian(s') Name(s): _____

Address: _____ **Phone #:** _____

_____ **Mobile Phone #:** _____

Email Address(es): _____

Place of Employment: _____ **Work Phone #:** _____

Parent/Guardian Information:

Parent(s')/Guardian(s') Name(s): _____

Address: _____ **Phone #:** _____

_____ **Mobile Phone #:** _____

Email Address(es): _____

Place of Employment: _____ **Work Phone #:** _____

Emergency Contact(s):

Emergency Contact #1: _____ **Relationship:** _____

Address: _____ **Phone #:** _____

Emergency Contact #2: _____ **Relationship:** _____

Address: _____ **Phone #:** _____

Medical Information:

Allergies: ☐ Yes ☐ No **Please specify:** _____

Epipen Required: Yes No

Does the client require medication? Yes No

Will the client require medication during the session? Yes No

Name of medication: _____ **Dose:** _____ **Time(s) taken:** _____

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Name of medication: _____ **Dose:** _____ **Time(s) taken:** _____

Name of medication: _____ **Dose:** _____ **Time(s) taken:** _____

Name of medication: _____ **Dose:** _____ **Time(s) taken:** _____

Name of medication: _____ **Dose:** _____ **Time(s) taken:** _____

Medical conditions: _____

Medical protocols for the condition(s):_____

_____

Therapeutic / Clinical Information:

Please indicate if there are any self-injurious behaviours of which we should be aware:

_____

_____

_____

If yes, please indicate if you have a specific safety plan in place at home:

_____

_____

Does the client use mobility aids (i.e., wheelchair, service dog, etc.)? ☐ Yes ☐ No

If yes, please describe: _____

Does the client require any safety accommodations (i.e., helmet, in the car, at swimming)?

☐ Yes ☐ No If yes, please describe: _____

_____

Is the client able to communicate verbally? ☐ Yes ☐ No

If yes, please describe the level at which the client is able to communicate verbally (i.e., minimal words, full sentences, etc.).

_____

_____

Is the client able to use sign language to communicate? ☐ Yes ☐ No

Does the client have specific sensory needs (i.e., auditory, visual, tactile, vestibular (movement and positioning), etc.)? Please describe:

_____

_____

Please describe the client's strengths and areas you wish to see developed:

_____

_____

_____

_____

Please describe and explain any safety or clinical plans that are in place at home or school:

_____

_____

_____

_____

Activities/Sports of Interest:

_____

_____

Activities/Sports Disliked:

_____

_____

What is the client's swimming level?

_____

Please indicate any concerns with the client's ability to participate in swimming:

_____

_____

Please indicate any toileting concerns for the client.

_____

_____

Please indicate food likes/dislikes for the client.

_____

_____

_____

Is the client on a special diet? If so, please describe.

_____

_____

_____

Assessment of Daily Living Activities:

To help us better understand the client's needs and abilities, please circle the appropriate rating of your client's ability to perform the following daily living activities:

1. **Toilet Use:** using the toilet, cleansing self, adjusting clothes, etc.
☐ Independent ☐ Limited Assistance ☐ Extensive Assistance ☐ Dependence

2. **Personal Hygiene:** ability to perform personal hygiene (combing hair, brushing teeth, washing/drying face and hands)
☐ Independent ☐ Limited Assistance ☐ Extensive Assistance ☐ Dependence

3. **Self-Regulation Skills:** ability to regulate and control their emotions when frustrated, anxious, and/or upset.
☐ Independent ☐ Limited Assistance ☐ Extensive Assistance ☐ Dependence

4. **Bathing:** ability to take a full bath/shower.
☐ Independent ☐ Limited Assistance ☐ Extensive Assistance ☐ Dependence

5. **Cognitive Ability to Make Decisions**
☐ Independent ☐ Some Difficulty ☐ Extensive Difficulty ☐ Severely Dependence
Decisions

6. **Behaviour Symptoms**
a.) How often does the client get lost or wander (ex. Moves with no rational purpose, seemingly oblivious to needs or safety)?
☐ Never ☐ Sometimes ☐ Often

b.) How often is the individual verbally abusive to others? (Others were threatened, screamed at, cursed at, etc.)
☐ Never ☐ Sometimes ☐ Often

c.) Was the verbal abuse easily altered or re-directed?
☐ ☐ No
Yes

d.) How often is the individual physically abusive to others (ex. Others were hit, shoved, scratched, etc.)?
☐ Never ☐ Sometimes ☐ Often

e.) Was the physical abuse easily altered or re-directed?
☐ Yes ☐ No

f.) How often does the client exhibit socially inappropriate/disruptive behaviour (ex. Makes disruptive sounds, noisiness, screaming, self-abusive acts, sexual behaviour or disrobing in public, smeared/threw food/feces, hoarding, rummaging through other's belongings, etc.)

☐ Never ☐ Sometimes ☐ Often

Please indicate the inappropriate/disruptive behaviours the client engages in:

_____

_____

Please do not hesitate to include any additional information regarding the client and/or their exceptionality.

_____

_____

_____

_____

MAIN STREET
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Service Request - Information

Services Offered	***Duration***	***Price***	***Services Requested***
Summer Camp	*Monday – Friday (9am to 4pm)*	*$85.00 per day*	*Yes*
Early Drop Off	*Monday – Friday (8am to 9am)*	*Included*	*Yes* ☐ *No* ☐
Late Pick Up	*Monday – Friday (4pm to 5pm)*	*Included*	*Yes* ☐ *No* ☐
1:1 Staff Support	*Hourly*	*$25.00 per hour*	*Yes* ☐ *No* ☐
Transportation	*Price per km*	*$1.25 per km*	*Yes* ☐ *No* ☐

July 2019 – Please indicate the days your child will be attending

Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*
8 ☐	*9* ☐	*10* ☐	*11* ☐	*12* ☐
15 ☐	*16* ☐	*17* ☐	*18* ☐	*19* ☐
22 ☐	*23* ☐	*24* ☐	*25* ☐	*26* ☐
29 ☐	*30* ☐	*31* ☐	*1* ☐	*2* ☐

August 2019– Please indicate the days your child will be attending

Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*
5 -HOLIDAY	*6* ☐	*7* ☐	*8* ☐	*9* ☐
12 ☐	*13* ☐	*14* ☐	*15* ☐	*16* ☐
19 ☐	*20* ☐	*21* ☐	*22* ☐	*23* ☐
26 ☐	*27* ☐	*28* ☐	*29* ☐	*30* ☐

*Worker Name/Organization (if applicable)*_____

Additional Notes: _____

Funding Letter Attached: _____ *Completed By (Staff Name):* _____

The placing agency / or legal guardian agrees to pay Main Street Community Services the Ministry approved pre-diem rate and all fees for the programs requested. Funds are to be received no later than 30 days after services is rendered. The placing agency / or legal guardian also agrees to clarify any error or omission with respect to payments with Main Street Community Services and adjust records accordingly.

Signature: _____ Date : _____

MAIN STREET
Community Services

CONSENT FOR SERVICES

I, _____ (parent/guardian) agree to have my child

_____ attend this MSCS program from

_____ to _____ 20___. I understand that Main Street Community Services will not be held accountable for any undue harm my child may receive while engaging in recreational activities.

Parent/Guardian Signature: _____

Dated this _____ day of _____, 20___ in the city of Ottawa.

Please make all cheques payable to Main Street Community Services

*****We are obligated, by the laws governing Children's Aid Societies and the Child and Family Services Act of Ontario, and Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act Ontario, to report and disclose of information that indicates a suspicion of abuse*****

RESTRAINT CONSENT

I accept that the qualified staff of MSCS, may use physical restraints in the event that it is necessary to protect my child's own safety or protect the safety of others. It is understood that a physical restraint refers to the practices acquired in training through CPI (Crisis Prevention Institute) or TCI (Training in Crisis Intervention). No restraints shall be used as method of punishment. I will be informed upon pick-up if a restraint was used on my child on that day.

_____

Parent/Guardian Signature *Date*

MAIN STREET
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AUTHORIZATION FOR USE OF PHOTOS

I, _____, authorize the use of my son or daughter,

_____, photo to be used by Main Street Community Services for the following purposes.

Please check off any and all of the following photo opportunities that you give us approval for:

_____ Brochures, flyers, etc.

_____ Internal (for example: displays at homes or at the centre, etc.)

_____ Website

_____ Fundraising Initiatives (i.e. slide show for annual fundraiser)

Parent/Guardian signature: _____ Date: _____

Witness: _____ Date: _____