Discovered Treasures Summer Camp Pre-Registration Form

Please note that due to COVID-19 all Community based programs are closed until further notice. We are unable to confirm Summer camp dates or availability at this time. We are continuing to accept pre-registration to ensure continuity of services should we be able to operate.

Thank you for your understanding and patience during such challenging times.

PLEASE ATTACH CURRENT PHOTO OF YOUR CHILD

Client Information:

Client Name: _____Prefers to be called: _____

Date of Birth: _____ Age at registration: _____

Address: _____

Home phone number: _____

Ethnicity: _____Religion: _____

Client's OHIP #: ____ _____ Copy of OHIP attached: YES☐ NO☐

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:

_____

Other notable features:

_____

Parent/Guardian Information:

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

_____

Address: _____

Home Phone #: _____

Mobile Phone #: _____

Email Address(es):

_____

Place of Employment: _____Work Phone #: _____

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

_____

Address: _____

Home Phone #: _____

Mobile Phone #: _____

Email Address(es):

_____

Place of Employment: _____Work Phone #: _____

Emergency Contact Information:

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: _____

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: _____

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:
Please feel free to attach any clinical documents. Please provide title of document (s) attached

_____

_____

_____

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 check the appropriate rating of your child's ability to perform the following daily living activities:

Toilet Use: using the toilet, cleansing self, adjusting clothes, etc.

Independent ☐ Limited ☐ Assistance ☐ Extensive Assistance ☐ Dependence ☐

Personal Hygiene: ability to perform personal hygiene (For example combing hair, brushing teeth, washing/drying face and hands)

Independent ☐ Limited ☐ Assistance ☐ Extensive Assistance ☐ Dependence ☐

Self-Regulation Skills: ability to regulate and control their emotions when frustrated, anxious, and/or upset.

Independent ☐ Limited ☐ Assistance ☐ Extensive Assistance ☐ Dependence ☐

Bathing - ability to take a full bath/shower.

Independent ☐ Limited ☐ Assistance ☐ Extensive Assistance ☐ Dependence ☐

Cognitive Ability to Make Decisions

Independent Decisions

Some Difficulty ☐ Extensive Difficulty ☐ Severely Dependence ☐

_____

_____

_____

Behaviour Symptoms

How often does the client get lost or wander (ex. Moves with no rational purpose, seemingly oblivious to needs or safety)?

Never ☐ Sometimes ☐ Often ☐

_____

_____

_____

How often is the individual verbally abusive to others? (Others were threatened, screamed at, cursed at, etc.)

Never ☐ Sometimes ☐ Often ☐

_____

_____

_____

If yes, was the verbal abuse easily altered or re-directed?

Yes ☐ No ☐

_____

_____

_____

How often is the individual physically abusive to others (ex. Others were hit, shoved, scratched, etc.)?

Never ☐ Sometimes ☐ Often ☐

_____

_____

_____

Was the physical abuse easily altered or re-directed?

Yes ☐ No ☐

_____

_____

_____

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 Community Services Discovered Treasures Summer camp operates Monday to Friday excluding holidays.

Services offered;

Summer Camp	9:00 am – 4:00 pm	$85.00 per day	Yes ☐ No ☐
Before camp program	8:00 am – 9:00 am	Included in price	Yes ☐ No ☐
After camp program	4:00 pm – 5:00 pm	Included in price	Yes ☐ No ☐
1:1 staff support	Hourly	$25.00 per hour	Yes ☐ No ☐
Transportation	Per Km	$1.25 per km	Yes ☐ No ☐

July 2020 – Please indicate the days you would like your child to attend

Monday	Tuesday	Wednesday	Thursday	Friday
☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
☐ 13	☐ 14	☐ 15	☐ 16	☐ 17
☐ 20	☐ 21	☐ 22	☐ 23	☐ 24
☐ 27	☐ 28	☐ 29	☐ 30	☐ 31

August 2020 – Please indicate the days you would like your child to attend

Monday	Tuesday	Wednesday	Thursday	Friday
	☐ 4	☐ 5	☐ 6	☐ 7
☐ 10	☐ 11	☐ 12	☐ 13	☐ 14
☐ 17	☐ 18	☐ 19	☐ 20	☐ 21
☐ 24	☐ 25	☐ 26	☐ 27	☐ 28

All dates and availability subject to change

Worker Information

Worker Name_____

Worker Organization_____

Worker phone number_____

Additional Notes:

_____

_____

_____

_____

_____

_____

Funding Letter: Yes ☐ No ☐ Attached: Yes ☐ No ☐

The placing agency / or legal guardian agrees to pay Main Street Community Services 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 : _____

CONSENT FOR SERVICES

I, _____ (parent/guardian) agree to have my child _____ attend MSCS Discovered Treasures Summer camp program from;_____ to _____ 2020.

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 _____, 2020 in the city of Ottawa.

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). 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

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: _____