Inspiration Driven.

APPLICATION FOR SERVICE

Program Participant's Information:		
Last Name:	First Name:	
Gender: M F	Date of Birth:	
Social Insurance No.:	Health Card No.:	
Address:	Apt./Unit:	Phone No.:
City:	Postal Code:	
Residential Information (if applicable):		
Name of Agency:	Contact Person:	
Address:	Apt./Unit:	Phone No.:
City:	Postal Code:	
Referred by: (name and address of person referring program participant)		
Name:	Relationship to applicant:	
Name of agency (if applicable):		
Address:	Apt./Unit:	Phone No:
Diagnosis:		
Current challenges:		

Mother's Information:	
Last Name:	First Name:
Address:	Apt./Unit:
City:	Postal Code:
Home Phone:	Cell Phone:
Occupation:	
Marital Status (please circle): Married Single Separated Divorced Common Law Widowed Deceased	
Father's Information:	
Last Name:	First Name:
Address:	Apt./Unit:
City:	Postal Code:
Home Phone:	Cell Phone:
Occupation:	
Marital Status (please circle): Married Single Separated Divorced Common Law Widowed Deceased	

Siblings:

Name	Age	Present School/Grade or Occupation

Current Functioning Level: Please indicate age level for each area of development and include strengths, weaknesses and development delays at each level.		
Area of Development	**Age**	**Comments**
Reading Comprehension		
Writing		
Math		
Gross Motor Skills		
Fine Motor Skills		
Social Skills		
Imagination		
Verbal Expression		
Verbal Understanding/Comprehension		
Drawing/Art		
Sports		
Music		

Disability/Diagnosis/Presenting Difficulties:
Describe the program participant's disability:
How old was the program participant when you became concerned about his/her developments:
Please indicate what your concerns were:
Who made the diagnosis:
Which Hospital/Agency:
Are there reports? Yes No If yes, is reported attached? Yes No (please circle)
Social Development: Describe how the program participant interacts with:
Parents:
Siblings:
Extended Family:
Peers:
Teachers/Staff:

Emotional Development:
Describe how the program participant responds to feelings of frustration/anger/success/excitement:
Has he/she developed any coping strategies to deal with difficult emotions?
Behavioural Issues:
Describe any behavioural concerns:
What does the program participant do?
Medical History:
Hearing
Has the program participant had his/her hearing tested?
What were the results?
Are there any hearing difficulties?
Are hearing aids required?
Reports attached? Yes/No (please circle)

Vision
Has the program participant had his/her vision tested?
What were the results?
Are there any visual difficulties:
Does the program participant wear glasses?
Reports attached? Yes/No (please circle)
Allergies
Does the program participant have any allergies?
Please list:
Any treatment/medication/protocols or procedures required?
Reports attached? Yes/No (Please circle)
Epilepsy/Seizures
Does the program participant current experience seizures?
Any treatment or medication?
Was there seizure activity previously?
Seizure protocol?
Reports attached? Yes/No (please circle)
Diabetes
Does the program participant have diabetes?
What is the treatment plan?
Reports attached? Yes/No (please circle)

Asthma
Does the program participant have asthma?
What is the treatment plan?
Reports attached? Yes/No (please circle)
Heart
Does the program participant have any heart problems?
What is the treatment plan?
Reports attached? Yes/No (please circle)
High Blood Pressure
Does the program participant have high blood pressure?
What is the treatment plan?
Reports attached? Yes/No (please circle)
Hospitalizations:
Has the program participant been hospitalized?
If yes, please provide the following information:

Date	Hospital	Reason	Treatment Received

Are there other medical concerns relevant to the program participant's health?
Additional Comments: **Family Medical History:**
Mother
Health:

Hospitalizations:
Father
Health:
Hospitalizations:
Siblings
Health:
Hospitalizations:
Grandparents (briefly describe):
Extended Family Members (example: niece, nephew, aunt, etc.) – briefly describe
Medical Information:
Name of program participants family doctor:
Address: Phone No.:
When was the program participant's last medical check-up?

Significant information:

Please list any other doctors involved with this program participant such as neurologist, psychiatrist, etc.

Name of Doctor	**Phone Number**	**Reason for Contact**	**Treatment Received**
Is a report attached? Yes/No (please circle)			
Name of Doctor	**Phone Number**	**Reason for Contact**	**Treatment Received**
Is a report attached?			
Name of Doctor	**Phone Number**	**Reason for Contact**	**Treatment Received**
Is a report attached?			
Additional Comments:			
Educational History:			
Current School or Day Program:			
Address:		Phone No.:	
School Board:		Teacher:	
Reports attached: __ Individual Education Plan (IEP) __ Identification, Placement and Review Committee IPRC			

Name of School	**Address**	**Start/End Dates**

Reports attached? Yes/No (please circle)		
Name of School	**Address**	**Start/End Dates**
Reports attached? Yes/No (please circle)		
Name of School	**Address**	**Start/End Dates**
Reports attached? Yes/No (please circle)		

Kindly attach the following reports:

Report Type	**Attached**	**Report Type**	**Attached**
Last two years school reports, IEP's		Speech-Language reports	
IPRC reports		Occupational Therapy reports	
Psychoeducational Reports		Physiotherapy reports	
Behaviour Consultant Reports		Safety Plans	

Assessments:

Psychiatric Reports:
Name of Doctor: Phone No.:

Date of Assessment: Report Attached: Yes/No (please circle)

Psychological Reports:
Name of Doctor: Phone No.:

Date of Assessment: Report Attached: Yes/No (please circle)

Social Work/Psychosocial Reports:
Social Worker/Therapist: Phone No.:

Date of Assessment: Report Attached: Yes/No (please circle)

Family Therapy:
Family Therapist/Social Worker: Phone No.:

Date of Assessment: Report Attached: Yes/No (please circle)

Is there any history or concerns relating to abuse (neglect/physical/emotional/sexual)?
If yes, please describe briefly:
Children's Aid Society/Child Welfare:

Has there been any involvement with the Children's Aid Society? If yes, can you indicate the reason and date of involvement:
If still involved, who is the contact person? Name: Phone No.:
Sensory Integration:
Has the program participant had Sensory Integration Therapy? Yes/No (please circle) Is there a report available from an Occupational Therapist? What interventions are currently used to assist the program participant?
Needs and Desires of the Child and Family:
Needs and Desires communicated by the program participant:
Needs and Desires communicated from the family on behalf of the program participant:
Participation programs and services, preferred activities, successes and challenges:

Cultural/Religious Considerations: Are there any cultural considerations regarding the program participant? Yes/No If yes, please describe briefly:

Are there any religious considerations regarding the program participant? Yes/No If yes, please describe briefly:
Emergency Contact Numbers: Please provide the names of two people who can be contacted in case of an emergency: Name: Relationship: Home Phone: Cell Phone:
Name: Relationship: Home Phone: Cell Phone:

_____ _____

Signature of Program Participant Date

_____ _____

Signature of Parent/Guardian (if required) Date