



Applicant Information

Identifying Information

Applicant's Name: _____ **Sex:** _____
FIRST MIDDLE LAST

Applicant's Date of Birth: _____ **Place of Birth:** _____
(D/M/Y) TOWN/COUNTRY

Mother/Guardian: _____ **Relationship:** _____

Father/Guardian: _____ **Relationship:** _____

Address: _____
_____ **Postal Code:** _____

Applicant's Current Address: _____
_____ **Postal Code:** _____

Home Phone Number: _____ **Cell Phone Number:** _____

Occupations of Parent/Guardian:

	Mother	Father
Occupation:	_____	_____
Place of Employment:	_____	_____
Address:	_____	_____
	_____	_____
Phone Number:	_____	_____

Family Information

If applicant does not live with both parents, name and address of other parent:

_____ **Postal Code:** _____

Telephone (home): _____ **(business):** _____

If applicant does not live at home, the family's involvement with the applicant is:

Active: _____ **Moderate:** _____ **Rare:** _____

Comments on type of involvement: _____

Siblings and Dates of Birth: _____

Others living in household with applicant (grandparents, other relatives, friends etc.):

Medical Information

Applicant's Family Physician: _____
Address: _____
Postal Code: _____
Phone: _____

Specialists (name, address, phone):

Applicant's Dentist: _____
Address: _____
Phone: _____

Date of Last Visit: _____

Dental Insurance: _____

Neurologist: _____

Other: _____

Diagnosis: _____

Weight: _____ **pounds** **or** _____ **kilograms**

Height: _____ **inches** **or** _____ **centimeters**

Please describe applicant's mobility:

a) **No difficulty walking** (eg. Able to walk independently, goes up and down stairs without help.)

b) **Walks only with assistance** (eg. Walker, crutches, holds on to someone else or a railing.)

c) **Unable to walk, but not a bed patient** (eg. Needs help getting out of bed, uses a wheelchair.)

Comments: _____

Please list any therapy your child has received (eg. Occupational, Physical, Speech, Behavioural.)

	Name of Centre	Address	Therapy
a)	_____	_____	_____
b)	_____	_____	_____
c)	_____	_____	_____
d)	_____	_____	_____

Vision: a) **no difficulty** _____

b) **difficulty** _____

c) **no usable vision** _____

d) **special device** _____

e) **medical/surgical treatment** _____

Hearing: a) **no difficulty** _____

b) **difficulty** _____

c) **no usable vision** _____

d) **special device** _____

e) **medical/surgical treatment:** _____

Medical History:

a) **Bronchitis:** _____

b) **Pneumonia:** _____

c) **Surgical History:** _____

d) **Major Injuries:** _____

Immunization Record:

Vaccine	Date
_____	_____
_____	_____
_____	_____
_____	_____

Has the applicant been screened for Hep B? _____ **If "yes" give date:** _____

Has the applicant been immunized for Hep B? _____ **If "yes" give date:** _____

Is the applicant a Hep B carrier? **Yes** _____ **No** _____

List the communicable diseases the applicant has had. (eg. Chicken pox, measles, mumps, etc.)

Seizure History: Please specify if the applicant currently has seizures, how often, what kind, aura, how long they last, etc.

Date of Last Seizure: _____

Allergies: Please specify what the applicant is allergic to, what the symptoms of the allergies are and what medicine is used to counteract the allergic reaction.

- a) **Medications:** _____
- b) **Food:** _____
- c) **Other:** _____

Medication: Please identify what kind of medicine the applicant takes, how often, and for what purpose. Please include "occasional" medicine like cold remedies, etc.

What method do you find is best for administering medication to the applicant?

Applicant's Health Card Number: _____

Nutrition

- 1) **Diet Instructions:** _____
- 2) **Favourite foods & drinks:** _____
- 3) **Strong dislikes:** _____
- 4) **Outline present method of feeding** (eg. Texture, cup, bottle, G-tube):

Elimination

- 1) **How often does the applicant have a B.M.?** _____

- 2) **Does the applicant require laxatives or suppositories to assist B.M. pattern?**

- 3) **Is the applicant on a toilet-training program? If so, describe.** _____

Behaviour Information

Please describe the applicant's level of ability in the following areas:

	Independent	Partially Dependent	Totally Dependent
a) toileting	_____	_____	_____
b) dressing	_____	_____	_____
c) eating	_____	_____	_____
d) bathing/basic grooming	_____	_____	_____

Comments: _____

What are the applicant's principle needs? _____

Describe how the applicant relates to other? (eg. peers, adults, etc.)

Daily Routine: _____

Favourite Activities: _____

Can/does the applicant talk? _____

What language(s) does the applicant speak? _____

What language(s) does the applicant understand? _____

Does the applicant use a communication system other than speech? (Bliss symbols, gestures etc.)

Please specify. _____

Can people understand the applicant's communication? _____

Comments: _____

For each of the following items, check whether or not it is a problem:

	No Problem	Problem
a) following directions:	_____	_____
b) fighting with others:	_____	_____
c) destroying property:	_____	_____
d) self-injurious behaviour:	_____	_____
e) tolerance for new situations:	_____	_____
f) personal safety:	_____	_____
g) attention span:	_____	_____
h) other (please specify)		

Is there anything that you use as a reward or reinforcer? (eg. music, hugs, etc.)

In the self-help skills area, what is the order of priority for the following, from the point of view of the person who knows the applicant best? (Use number 1 for highest priority and number 6 for lowest.)

- a) toileting _____
- b) dressing _____
- c) eating _____
- d) bathing _____
- e) grooming _____
- f) personal needs (eg. Blowing nose) _____

Comments: _____

Educational Information

Please list all education programs the applicant has attended. Start with the most recent.

Name of School/Program	Contact Person	Telephone
_____	_____	_____
_____	_____	_____
_____	_____	_____

List the skills presently being worked on at school.

Residential Information

If the applicant has lived anywhere other than in on home within the past 5 years, list places of residence.

Residence: _____	Residence: _____
Address: _____	Address: _____
Telephone: _____	Telephone: _____
Contact Person: _____	Contact Person: _____

Residence: _____	Residence: _____
Address: _____	Address: _____
_____	_____

Visitor Information

Please list the persons who may or may not visit the applicant.

May	May Not
a) _____	a) _____
b) _____	b) _____
c) _____	c) _____
d) _____	d) _____
e) _____	e) _____

Comments

Source of Information (name, address, telephone)

Please attach a copy of the applicant's Birth Certificate.

PARENT/GUARDIAN/REFERRING AGENCY'S SIGNATURE

DATE

RED ROOF RETREAT REPRESENTATIVE'S SIGNATURE

DATE