



## PARTICIPANT APPLICATION FORM

Higher Ground:

Compass:  Mon.  Tues.  Wed.  Thurs.  Fri.

Individual's Name: \_\_\_\_\_

Date of Birth (dd/mm/yyyy): \_\_\_\_\_ Age: \_\_\_\_\_

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

Home Phone Number: \_\_\_\_\_

Parents/Guardians Names: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Address (if different from the applicant): \_\_\_\_\_

Individual lives with:

- Mother                       Father                       Legal Guardian  
 Group Home                       Independently                       Other, please specify: \_\_\_\_\_

Emergency Contact (other than parent/guardian)

Names: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Address (if different from the applicant): \_\_\_\_\_

Name 2 people who authorized to remove the participant from the program:

1. _____	_____
Name	Relationship to participant

2. _____	_____
Name	Relationship to participant

Is there anyone who is not allowed to remove the participant from the program?

1. _____	_____
Name	Relationship to participant

2. _____	_____
Name	Relationship to participant

List all medical illnesses, information and conditions:

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List all current medications:

Medications	Dosage	Time(s)	Reason for Taking

Does the applicant willingly take the required medication as prescribed:

Yes

No, please describe: \_\_\_\_\_

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Family Physician Name: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_

OHIP Card: \_\_\_\_\_

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Does the applicant have any allergies? \_\_\_\_\_

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Does the applicant carry an epi-pen? \_\_\_\_\_

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Are there any dietary restrictions? Please describe. \_\_\_\_\_

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Please indicate if the applicant uses any of the following and when they need to use the device:

Device used:	When to use:
<input type="checkbox"/> wheelchair	
<input type="checkbox"/> walker	
<input type="checkbox"/> braces	
<input type="checkbox"/> AFOs	
<input type="checkbox"/> eating utensils	
<input type="checkbox"/> helmet	
<input type="checkbox"/> assistive technology	
<input type="checkbox"/> hearing aids	
<input type="checkbox"/> glasses	

Does the applicant need assistance using the washroom? Yes No

Please indicate the level of support needed:

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Please indicate if you have any safety concerns regarding the applicant:

- risk of choking  self-injurious behavior  
 tends to wander  runs away from caregivers  
 other, please specify: \_\_\_\_\_

How does the applicant interact with others (please check all that apply):

- prefers to play by themselves  prefers to play one to one (usually an adult)  
 prefers to play one to one (usually a peer)  enjoys larger group activity  
 able to follow simple instructions  extrovert  
 introvert

Please indicate which types of behaviour the applicant may present when agitated, frustrated, anxious etc.

- biting others  hitting/striking others  kicking  
 yelling  swearing  throwing objects  
 spitting  self-injurious behavior  
 other, please specify: \_\_\_\_\_

How often do these behaviors occur?

- rarely  occasionally  weekly  
 other, please specify: \_\_\_\_\_

What are some of the behavioral triggers?

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What strategies are used to help manage these behaviours?

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Describe a recent incident that has occurred with the applicant and how it was managed?

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How does the applicant learn/communicate?

- is able to figure out a task when told
- is able to figure out a task when shown
- understands complex instructions
- understands simple directions
- responds to visuals
- uses single words
- uses sign language

What are some of the applicant's favorite activities?

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What are the applicant's least favorite activities?

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What do you believe are some of the applicant's strengths and abilities?

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What are some of the learning challenges the applicant has?

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What was the classroom placement of the applicant during the high school education?

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List the goal(s) for the applicant during their time at Concord in the City:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Do you have any concerns with the applicant participating in Concord in the City programs?

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