APPLICATION FORM

Participant's General Information

Last Name: ________________________ First Name: ____________________________

Address: ____ City: _____________________

Postal Code: ________________ Email: __________________________________

Phone (Home): ___________________________ Phone (Cell): ___________________________

Date of Birth: (YYYY/ MM/ DD) _____________________________ Gender: _______________

Contact Information of Parent/ Guardian:

Name of Parent/ Guardian 1: ____________________ Relation to applicant: _________________

Parent / Guardian 1 (Cell #): ____________________ Parent / Guardian 2 (Work #): __________________

Name of Parent/ Guardian 2: ____________________ Relation to applicant: _________________

Parent / Guardian 1 (Cell #): ____________________ Parent / Guardian 2 (Work #): __________________

Emergency Contact Information:

Name of Emergency Contact: ______________________ Relation to applicant:

_____________Primary Contact Number: __________________________

Participants Health Information:

Primary Physician Name: ___________________________ Address: _____________________

Phone: _____________________________ Health Card Number: ____________________________

Please check the following that apply:

Neurodevelopmental Disorder		**Other Disorders**	
Autism Spectrum Disorder		Visually Impaired	
Intellectual Development Disorder		Hearing Impaired	
Learning Disability		Epilepsy or Seizures	
Brain or Neurological Injury		Speech Difficulty	
Cerebral Palsy		Mobility Challenges	
Impulse Control		Medical Illness	
Other (Specify)		Physical Disability	
		Mental Health Disability	

Please specify in the space below, any behaviours that the participant currently has (ex: aggressive, self harm, disruptive, wandering/ pacing, etc..)

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Please indicate any allergies that the participant has, any possible reactions, and if an Epi- Pen is required for the individual:

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Please list any medications required by the individual: *(Please complete attached medication form)*

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Skills and Abilities

Please check the following that apply:

Independent		**Not Independent**	
Requires minimal supervision		Requires Constant Supervision	
Follows verbal instructions		Will wander	
Can toilet independently		Needs assistance with toileting	
Able to feed independently		Needs assistance with feeding	
Can do up buttons/ zippers		Needs assistance with buttons/ zippers	
Can communicate needs verbally		Cannot communicate needs verbally	

Please provide the last IEP from the participants school to assist with planning

Specific goals to be implemented at Community Access Learning Centre for the Participant:

Please check all that apply:

Vocational Training Skills		Technological Awareness Skills	
Life Skills		Communication skills	
Social Skills		Community Awareness	
Culinary Skills		Independence	

Please specify the participants personal interests

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Attendance (Circle all participation days that apply)

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Additional Comments/ Concerns:

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How did you find out about us?

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