



ADAPTABILITIES

CREATING SUCCESS FOR LIFE

Intake
2017-2018

About Me

Please note: Forms are in the first person

Participant

Name: _____
First Name Middle Initial Last Name

Emergency Contacts (2 - Other than Parents/Guardians)

| | |
|--------------------|--------------------|
| Name: _____ | Name: _____ |
| Relationship _____ | Relationship _____ |
| Cell Phone # _____ | Cell Phone # _____ |
| Home Phone # _____ | Home Phone # _____ |
| Work Phone # _____ | Work Phone # _____ |

Relationships:

Who is important in your life? (Family, friends, natural and/or paid supports)

Social Interaction:

Are you an introvert/extrovert? Comment on how you get along with others?

Sensory Needs:

Touch, smell, oral-tactile, taste, visual, auditory, what are their sensory needs?

How to Support Me

AdaptAbilities believes all behavior is simply a form of communicating one's needs. Behaviors do not occur without a reason. The first step in supporting a person with behaviors is getting to know them.

Communicating My Needs:

1. When I am upset, angry, afraid, frustrated, confused, or sad, I react by: (consider environment - home, school and/or in community)

None Swearing Hitting Biting Kicking Refusal Hair Pulling

Explain: _____

What is the frequency, duration, and intensity? _____

2. When I am upset, or starting to get upset, I communicate by:

None Crying Withdrawal Refusal Yelling Pouting
Swearing Screaming Self-Harm Aggression Faking Injury/Illness

Explain: _____

3. What environment is most successful for you? (ie: Away from loud noises, less crowded, etc.)

4. When you are getting frustrated, how would you like to be supported?

Quiet Time My Own Space Go for Walk Counting
Redirection Verbal Reminder

Explain: _____

5. Are there any other issues you believe we should be aware of?

Goal Sheet

Fill out ONLY if you are 17 years or younger

Participant's Name: _____ Date: _____

We like to focus on personal development, starting with skills and strengths of each person. List strengths of your child (ie: Social, recreation, communication, gross/fine motor skills, etc.)

AdaptAbilities focuses on “Creating Success – For Life” and integrates three components into our day: Essential Life Skills, Expressive Arts, and Recreation and Motor Development.

Choose three goals from each component, numbering 1, 2 and 3, with #1 being your highest priority.

Goals:

1. **Essential Life Skills** – Skills used in everyday social activities such as:

| | |
|--|---|
| <input type="checkbox"/> Focus on task | <input type="checkbox"/> Respecting space and boundaries |
| <input type="checkbox"/> Increase attention span | <input type="checkbox"/> Borrowing versus taking |
| <input type="checkbox"/> Improve communication | <input type="checkbox"/> Taking turns and sharing |
| <input type="checkbox"/> Manners | <input type="checkbox"/> Proper food choices – healthy snacks |
| <input type="checkbox"/> Problem solving | <input type="checkbox"/> Telling time |
| <input type="checkbox"/> Anger management | <input type="checkbox"/> Money |
| <input type="checkbox"/> Following instructions | <input type="checkbox"/> Counting |
| <input type="checkbox"/> Adapting to change | <input type="checkbox"/> Increasing independence ie: dressing |
| <input type="checkbox"/> Making choices | |

Other: _____

2. **Expressive Arts** – Activities that encourage expression and creativity, such as:

| | |
|---|--|
| <input type="checkbox"/> Drawing | <input type="checkbox"/> Increased interest in various art forms |
| <input type="checkbox"/> Painting | <input type="checkbox"/> Express feelings through art |
| <input type="checkbox"/> Building and creating | <input type="checkbox"/> Increase communication through art |
| <input type="checkbox"/> Singing and/or music | |
| <input type="checkbox"/> Drama and theatre sports | |

Other: _____

3. **Recreation & Motor Development** – Leisure activities & fine/gross motor skills such as:

| | |
|---|---|
| <input type="checkbox"/> Running and/or jumping | <input type="checkbox"/> Playground skills |
| <input type="checkbox"/> Throwing and/or catching | <input type="checkbox"/> Playing games with others |
| <input type="checkbox"/> Swimming and/or bowling | <input type="checkbox"/> Interest in active living activities |
| <input type="checkbox"/> Climbing and/or swinging | <input type="checkbox"/> Sensory activities (specify): |
| <input type="checkbox"/> Improved coordination | <input type="checkbox"/> Printing |
| <input type="checkbox"/> Improved balance | <input type="checkbox"/> Coloring within the lines |

Other: _____

If you have any questions, or need some suggestions, feel free to contact us at (780) 431-8446

Personal Development

Fill out ONLY if you are 18 years or older

Skills and Strengths:

Are there any previous work/volunteer school or other experiences you have had that you are proud of, and would like to continue or build on? (ie: Work experiences, previous employment, good at working with young children, strong organizational skills, etc.)

Meaningful Days:

What are the things that you feel need to be included in your day/week in order for you to enjoy your day? (ie: Taking care of your home, chores, physical activity, contributing through volunteerism, having a morning coffee, paid employment, etc.)

Working On:

Are there specific skills or areas that you are working on gaining more independence? (Self-care, cooking, taking transit, laundry, money management, other skills/knowledge required to live independently).

Personal Development:

Is there anything you are passionate about learning or courses you are interested in taking (ie: art, computer, photography, cooking classes, drama groups, sports, public speaking, fitness, building model airplanes, drumming, guitar, etc.) Are you interested in any post-secondary opportunities? Are there things you have never tried that you would like to explore to see if they suit you?

PAR Questionnaire

Physical Activity Readiness (PAR) Questionnaire

Circle yes/no and provide an explanation as required.

- | | | |
|--|-----|----|
| 1. Has your doctor ever said that the individual has heart trouble? | YES | NO |
| 2. Do they frequently suffer from pains in their heart or chest? | YES | NO |
| 3. Does the individual often feel faint or have spells of dizziness? | YES | NO |
| 4. Has your doctor ever said that the individual has high blood pressure? | YES | NO |
| 5. Has your doctor ever told you that he/she has a bone or joint problem (ie: arthritis) that has been or may be aggravated by exercise? | YES | NO |
| 6. Does the participant have any perceptual/learning/motor delays? If yes, please specify: _____ | YES | NO |
| 7. Does the individual have any allergies? | YES | NO |
| 8. Is the individual currently taking any medication? List medications taken outside of AdaptAbilities Programming: _____ | YES | NO |

Signed this _____ day of _____, 20____, Edmonton, Alberta

Individual/Guardian/Primary Contact

Signature: Individual/Guardian/Primary Contact

Reviewed by: Staff Name

Staff Signature

Medical

Physician(s):

1. Name: _____ Address: _____ Ph #: _____

2. Name: _____ Address: _____ Ph #: _____

Preferred Hospital: _____ Ph #: _____

Alberta Health Care #: _____

Do you have health insurance? (ie: Blue Cross) Yes No

In the case of an emergency, AdaptAbilities will call an ambulance.

N. B. Family is responsible for the full cost of the ambulance, if not covered by insurance.

Medical Information:

Allergies: _____

Reaction: _____

Recommended Treatment for Reaction(s): _____

Drug Allergies: _____

Reaction: _____

Recommended Treatment for Reaction(s): _____

Seizures: Yes No

Type: _____ Frequency: _____

Duration: _____ Date of last seizure: _____

Reaction: Before: _____ During: _____

After: _____

Diabetes: Yes No

Is the participant on insulin? Yes No

How often do they need to check their blood sugar levels? _____

Do they need assistance? Yes No

Notes: _____

Communicable Disease(s)? Yes No

If yes, state the diagnoses: _____

Medical

Frequent Health Problems:

Is the participant prone to any of the following?

- Fainting Asthma Respiratory problems Heart problems Dizziness
 Infections Headaches Migraines Low blood pressure
 Faking illness High blood pressure

Please explain: _____

Is the participant *unable* to participate in physical activities for any reason?

What intensity of physical activity is reasonable for them?

- Light Moderate Heavy

Are there any other health concerns that you would like us to be aware of?

Special Dietary Needs:

Does the individual have a G-Tube?

- Yes No

If yes, you must complete a G-Tube Care Sheet (request form from office).

Food Preparations: None Soft Diced Pureed Thickened Fluids

Notes: _____

May NOT consume the following: Dairy Sugar Gluten Eggs Nuts

Other: _____

Individual/Parent/Guardian Waiver

All information provided is complete to the best of my knowledge. I have not withheld any information that will affect the care of the individual.

- I agree to be placed on the AdaptAbilities e-newsletter list to receive email notifications

 Individual/Parent/Guardian Signature Date

Medication Release

Participant Name: _____

Name of Parent/Guardian _____

If no medication is required, sign below

List medications administered by AdaptAbilities, including non-prescription medications (ie: over-the-counter and herbal remedies.)

| | | | | | |
|--|---|----------|--|---------|--|
| Medications to be returned: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly | | | | | |
| Medication Name | | | | | |
| Prescription? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Time(s): | | Dosage: | |
| Side Effects: | | | | | |
| Instructions: | | | | | |
| Medication Name | | | | | |
| Prescription? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Time(s): | | Dosage: | |
| Side Effects: | | | | | |
| Instructions: | | | | | |
| Medication Name | | | | | |
| Prescription? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Time(s): | | Dosage: | |
| Side Effects: | | | | | |
| Instructions: | | | | | |
| Medication Name | | | | | |
| Prescription? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Time(s): | | Dosage: | |
| Side Effects: | | | | | |
| Instructions: | | | | | |

Signed this _____ day of _____, 20____, Edmonton, Alberta

Individual/Guardian/Primary Contact

Signature: Individual/Guardian/Primary Contact

Reviewed by: Staff Name

Staff Signature



ADAPTABILITIES

CREATING SUCCESS FOR LIFE

Consent Forms

All waivers must be signed.

Assumption of Risk

On behalf of _____, as a parent/guardian, I _____ understand that there are risks/dangers, which are inherent to each specific activity provided by Alberta AdaptAbilities Association. These risks include, but are not limited to, the loss of personal property, the possibility of physical injury to them and other participants, such as muscle strain, broken bone(s), concussion, soft tissue damage, infectious disease, etc. including the possible risk of severe or fatal injury.

Alberta AdaptAbilities Association strives to provide awareness of risks associated with each of the programs/activities it offers. As a parent/guardian, I understand that it is my responsibility to ascertain if there are any health conditions which make it inadvisable for participation in an Alberta AdaptAbilities Association program. I also understand that I am responsible for any medical treatment or costs which may occur because of their participation.

I, the parent/guardian remise, release, and forever discharge Alberta AdaptAbilities Association, its heirs, successors, executives, administrators, directors, officers, employees, insurers, agents, and assigns of and from any and all manner of actions, causes of action, suits, debts, costs, claims, damages, whatsoever arising out of or in consequence of any loss, injury or damage of any kind sustained by child/adult in an Alberta AdaptAbilities Association program. In the event of an accident, I give permission for qualified Alberta AdaptAbilities Association staff to administer first aid and/or CPR, and/or accompany them in ambulance.

I understand that I will be responsible for the cost, in full, of any transportation, to and from the hospital or location of treatment, including but not limited to ambulance transportation.

I understand that I or another emergency contact must be available to pick up the person named above immediately at any time during an AdaptAbilities program due to emergency situations, sickness, or behaviors.

I acknowledge that I have read and understood this agreement. I understand, appreciate, and accept the risks associated with the participation in an Alberta AdaptAbilities Association program. As the parent/guardian, I consent for them to participate in Alberta AdaptAbilities Association programs from:

For the period of one year effective from the date of signature.

Signed this _____ day of _____, 20____, Edmonton, Alberta

Individual/Guardian/Primary Contact

Signature: Individual/Guardian/Primary Contact

Reviewed by: Staff Name

Staff Signature

Photo Disclosure

On behalf of _____, as a parent/guardian, I
_____ understand that there are times
when AdaptAbilities to take archival and/or promotional photos of the participants.

AdaptAbilities continues to be a leader in disability services within the City of Edmonton, and we strive to provide quality service to our families and the people who hire us.

To keep the legacy of our core purpose alive, and to further market our programs, we would like to promote successful experiences to prospective and current participants by displaying our people involved in meaningful days and purposeful support.

Please check the appropriate boxes for photo disclosure of pictures taken from:

For the period of one year effective from the date of signature.

Yes, photos may be used externally at the discretion of AdaptAbilities, ie: website, social media, and advertising purposes.

Yes, photos may be taken, and can only be used internally. Ie: within our program

No, I do not like photos taken. However, I understand that photos may be taken within Alberta AdaptAbilities Association programs, and there is a possibility that they will be situated within some photos. AdaptAbilities will not use their photo in any manner if this were to occur.

Signed this _____ day of _____, 20____, Edmonton, Alberta

Individual/Guardian/Primary Contact

Signature: Individual/Guardian/Primary Contact

Reviewed by: Staff Name

Staff Signature

Community Access/Field Trip

On behalf of _____, as a parent/guardian, I _____ understand that there are risks/dangers, when accessing community and participating in field trips.

Alberta AdaptAbilities Association wants to ensure a well-rounded experience for all, and focuses on the *development of the whole individual, physically, socially, mentally and emotionally within a safe and caring environment.*

To achieve the development of the whole person, Alberta AdaptAbilities Association utilizes as many resources within our community as possible to provide the best experience; thus, programs may include accessing the community and/or taking part in field trips. Transportation may be accessed through the use of the Edmonton Transit System (ETS), a cab company, chartered transportation, and/or the personal vehicle of an AdaptAbilities employee. Walking trips may also occur.

By signing this form, you are stating that you understand and accept the risks as outlined in the *Assumption of Risk* form previously completed. Alberta AdaptAbilities Association, its programs, and its employees make every effort to ensure everyone's safety while they attend any program held by Alberta AdaptAbilities Association. Accessing the community provides the opportunity to be a "part of" rather than just "in" community, which reinforces one to be a contributing member of their community.

I acknowledge that I have read and understood this agreement. I understand, appreciate, and accept the risks associated while accessing community in an Alberta AdaptAbilities Association program. As the parent/guardian, I consent for them to access community in Alberta AdaptAbilities Association programs, from:

For the period of one year effective from the date of signature.

Signed this _____ day of _____, 20____, Edmonton, Alberta

Individual/Guardian/Primary Contact

Signature: Individual/Guardian/Primary Contact

Reviewed by: Staff Name

Staff Signature

Sunscreen and Bug Spray Waiver

On behalf of _____, as a parent/guardian, I
_____ understand that there are
risks/dangers, when accessing community and participating in field trips.

Staff may apply sunscreen

Staff may apply bug spray

Application notes: _____

I, the person or parent/guardian remise, release, and forever discharge Alberta AdaptAbilities Association, its heirs, successors, executives, administrators, directors, officers, employees, insurers, agents and assigns of and from any manner of actions, causes of action, suits, debts, costs, claims, damages whatsoever arising out of or in consequence of any loss, injury or damage of any kind sustained by a child/adult due to the application of sunscreen or bug spray by Alberta AdaptAbilities Association or an employee of Alberta AdaptAbilities Association.

I acknowledge that I have read and understood this agreement. I understand, appreciate, and accept the risks associated with the application of sunscreen and/or bug spray by a representative of Alberta AdaptAbilities Association. As the parent/guardian, I consent to the application of sunscreen to the person named above from:

For the period of one year effective from the date of signature.

Signed this _____ day of _____, 20____, Edmonton, Alberta

Individual/Guardian/Primary Contact

Signature: Individual/Guardian/Primary Contact

Reviewed by: Staff Name

Staff Signature

Pick Up Release

On behalf of _____, as a parent/guardian, I _____ understand that there are risks/dangers, associated with releasing the participant, to the below mentioned person(s) upon pick up.

| # | Name (In Full) | Day/Date(s) | Notes |
|---|----------------|-------------|-------|
| 1 | | | |
| 2 | | | |
| 3 | | | |

I, the person or parent/guardian remise, release, and forever discharge Alberta AdaptAbilities Association, its heirs, successors, executives, administrators, directors, officers, employees, insurers, agents and assigns of and from any manner of actions, causes of action, suits, debts, costs, claims, damages whatsoever arising out of or in consequence of any loss, injury or damage of any kind sustained by a child/adult due to a representative of Alberta AdaptAbilities Association releasing the child/adult into the care of the above-mentioned person(s).

I acknowledge that I have read and understood this agreement. I understand, appreciate, and accept the risks associated with releasing the participant into the care of the above mentioned people. As the parent/guardian, I consent to the release of the participant into the care of the above named person(s) from:

For the period of one year effective from the date of signature.

Signed this _____ day of _____, 20____, Edmonton, Alberta

Individual/Guardian/Primary Contact

Signature: Individual/Guardian/Primary Contact

Reviewed by: Staff Name

Staff Signature

Release of Information

Authorization for the Release/Exchange of Confidential Information

On behalf of _____, as a parent/guardian, I _____ hereby authorize the release and exchange of any information including personal information, which would otherwise by law be considered to be privileged and private information to/from/between the following agency(s), individual(s)/professional(s).

| List Agency/Individual/Professional |
|--|
| <input checked="" type="checkbox"/> AdaptAbilities |
| <input type="checkbox"/> Funding Agency (Specify): |
| <input type="checkbox"/> School/Teacher (Specify): |
| <input type="checkbox"/> Social Worker (Specify): |
| <input type="checkbox"/> Other (Specify): |
| <input type="checkbox"/> Other (Specify): |

I choose not to authorize release of the following information, including:

This authorization shall be in effect from:

For the period of one year effective from the date of signature.

I understand that I may revoke this consent at any time by doing so in writing.

Any additional changes will require a new signature and corresponding date.

Signed this _____ day of _____, 20____, Edmonton, Alberta

Individual/Guardian/Primary Contact

Signature: Individual/Guardian/Primary Contact

Reviewed by: Staff Name

Staff Signature

