



ADAPTABILITIES

CREATING SUCCESS FOR LIFE

Annual Update

Update only information that has changed.

About Me

Participant

Name: _____
First Name Middle Initial Last Name

Date of Birth: _____ Age: _____
(dd/mm/yyyy)

Diagnosis(es): _____

Funder: _____ Caseworker: _____

School: _____ Program: _____ Grade Level: _____

Students in class: _____ Teacher plus # _____ Educational Assistant(s) _____

Do you have 1:1 support while in school? Yes No

Guardian(s)

Name(s): _____

Check one of the following:

Parent Permanent Guardian Temporary Guardian Social Worker Other:

If legal guardianship is in place, please provide a copy of documents, or communicate where you are in the process.

Home Ph #: _____ Work Ph #: _____ Cell #: _____

Preferred Contact Number: Home Work Cell

Address: _____ City: _____ Postal Code: _____

Email: _____

Emergency Contacts (2 - Other than Parents/Guardians)

Name: _____ Name: _____

Relationship _____ Relationship _____

Cell Phone # _____ Cell Phone # _____

Home Phone # _____ Home Phone # _____

Work Phone # _____ Work Phone # _____

Adaptive Equipment:

N/A Manual Wheelchair Electric Wheelchair Walker

Crutches Glasses Helmet Other: _____

Communication:

Verbal Limited Language Non-Verbal

What is your means of communication? I.e: iPad, Pictures, Stories?

Device/Technology PICS ASL Signed English

Other: _____

About Me

Personal/Self-Care:

What are my personal/self-care needs?

- None Eating Drinking Dressing
 Toileting Diapers Menstrual Care

Please explain: _____

Strengths:

What are my strengths, interests, talents, goals? What makes me GREAT? _____

Independence:

Daily routine, decisions, choice and control, what do I want to do independently? _____

Interests: (Activities that bring joy/meaning into my life)

I enjoy: _____

I do NOT enjoy: _____

I would like to try: _____

Social Interaction:

Am I an introvert/extrovert? How do I get along with others?

Sensory Needs:

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

Relationships:

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

Level of Support:

Flight Risk: YES NO

If yes, please explain: _____

I require a lifejacket while swimming? YES NO

How to Support Me

AdaptAbilities believes behavior is a form of communicating one's needs. Behaviors do not occur without a reason. The first step is getting to know the person.

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. A successful environment for me looks like: (ie: Away from loud noises, less crowded, etc.)

4. When I am getting frustrated, it is best to support me by:

Quiet Time My Own Space Go for Walk Counting

Redirection Verbal Reminder

Explain: _____

5. Other information that is important for you to know about me:

Transfer Assistance:

None One Person (Partially Dependent) One Person (Fully Dependent)

** We are unable to accommodate a two person transfer or a person in need of a mechanical lift.*

Strengths and Goals

Only fill out if you are 17 years or younger

Participant's Name: _____ Date: _____

AdaptAbilities focuses on the strengths and interests of our participants. A strength based approach has a simple premise - identify what is going well, do more of it, and build on it. Strengths are positive factors which support healthy development.

Strengths:

My strengths are: (ie: Social, recreation, communication, gross/fine motor skills, etc.)

Focusing on "Creating Success - For Life" AdaptAbilities integrates three components into our day: Essential Life Skills, Expressive Arts, and Recreation and Motor Development.

Goals:

I would like to work on the following (Check three per component):

1. **Essential Life Skills** - Skills used in personal development:

- | | |
|--|---|
| <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:

- | | |
|---|--|
| <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:

- | | |
|---|---|
| <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

Only fill out if you are 18 years or older

Participant's Name: _____ Date: _____

AdaptAbilities focuses on the strengths and interests of our participants. A strength based approach has a simple premise - identify what is going well, do more of it, and build on it. Strengths are positive factors which support healthy development.

Strengths:

I am proud of the following work/volunteer/school experiences. I would like to continue and build on: (ie: Work experiences, previous employment, good at working with young children, strong organizational skills, etc.)

Meaningful Days:

I need the following to enjoy and bring meaning into my days: (ie: Taking care of my home, physical activity, volunteering, morning coffee, time with friends/family, paid employment, etc.)

Working On:

I would like to work on the following areas to gain more independence: (Self-care, cooking, taking transit, laundry, money management, etc.)

Personal Development:

I am interested in the following learning opportunities to develop my skills: (Art, computer, cooking, fitness, post-secondary, things I have never tried before etc.)

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. Does the individual 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 the individual has a bone or joint problem (ie: arthritis) that has been or may be aggravated by exercise? | YES | NO |
| 6. Does the individual have any perceptual/learning/motor delays?
If yes, specify: _____ | YES | NO |
| 7. Does the individual have allergies? | YES | NO |
| 8. Is the individual currently taking medication? | 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

Insulin? YES NO

Frequency of blood sugar checks: _____

Requires assistance to check blood sugar? YES NO

Notes: _____

Communicable Disease(s)? YES NO

If yes, state the diagnoses: _____

Medical

Frequent Health Problems:

Is the individual prone to any of the following?

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

Please explain: _____

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

What intensity of physical activity is reasonable for the individual?

- Light Moderate Heavy

Are there any other health concerns?

Special Dietary Needs:

Does the individual have a G-Tube? YES NO

If yes, complete G-Tube Care form from office.

May NOT consume the following: Dairy Sugar Gluten Eggs Nuts

Other: _____

Consistency of Food: None Soft Diced Pureed
 Thickened Fluids (Indicate level)

Notes: _____

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:

Signed this _____ day of _____, 20____, Edmonton, Alberta expiring August 31, 2020.

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:

- Yes**, photos may be used externally at the discretion of AdaptAbilities, ie: website, social media, and advertising purposes.
- 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 expiring August 31, 2020

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:

Signed this _____ day of _____, 20____, Edmonton, Alberta expiring August 31, 2020

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:

Signed this _____ day of _____, 20____, Edmonton, Alberta expiring August 31, 2020

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:

Signed this _____ day of _____, 20____, Edmonton, Alberta expiring August 31, 2020

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:

- 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 expiring August 31, 2020

Individual/Guardian/Primary Contact

Signature: Individual/Guardian/Primary Contact

Reviewed by: Staff Name

Staff Signature