



ADAPTABILITIES

CREATING SUCCESS FOR LIFE

Annual Update 2021-2022

ABOUT ME

Participant

Name: _____
First Name Middle Initial Last Name

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

Diagnosis: _____

Funder: _____ Caseworker: _____

School: _____ Program: _____ Grade Level: _____

Number of Students in Class: _____ Teacher Plus Number _____ Educational Assistance

Do you have 1:1 support while in school? ☐ YES ☐ NO

Guardian(s)

Guardian #1

Name: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Preferred Contact Number:

☐ Home ☐ Work ☐ Cell

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.

Address: _____ City: _____ Postal Code: _____

Emergency Contacts (Two - Other Than Parents/Guardians)

Name: _____

Relationship: _____

Cell Phone: _____

Home Phone: _____

Name: _____

Relationship: _____

Cell Phone: _____

Home 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, etc.)

- ☐ Device/Technology ☐ PICS ☐ ADL ☐ Signed English
☐ Other: _____

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 To 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 behaviour is a form of communicating one's needs. Behaviours 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

Please 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

Please Explain:

3. A successful environment for me looks like: (i.e. 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

Please Explain:

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

Transfer Assistance

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

Please Note: We are unable to accommodate a two person transfer or a person in need of a medical lift.

STRENGTHS AND GOALS

Fill out **ONLY** 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: (i.e. social, recreation, communication, fine/gross motor skills, etc.)

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

Goals

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

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

- | | |
|--|--|
| ☐ Focus on task | ☐ Respecting space and boundaries |
| ☐ Increase attention span | ☐ Borrowing versus taking |
| ☐ Improve communication | ☐ Taking turns and sharing |
| ☐ Manners | ☐ Proper food choices, healthy snacks |
| ☐ Problem Solving | ☐ Telling time |
| ☐ Anger management | ☐ Money |
| ☐ Following instructions | ☐ Counting |
| ☐ Adapting to change | ☐ Increasing independence (i.e. dressing) |
| ☐ Making choices | |
| ☐ Other: _____ | |

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

- | | |
|--|--|
| ☐ Drawing | ☐ Drama and theatre sports |
| ☐ Painting | ☐ Increased interest in various art forms |
| ☐ Building and creating | ☐ Express feelings through art |
| ☐ Singing and/or music | ☐ Increase communication through art |
| ☐ Other: _____ | |

3. Recreation & Motor Development: leisure activities and fine/gross motor skills, such as:

- | | |
|---|---|
| ☐ Running and/or jumping | ☐ Improved coordination |
| ☐ Throwing and/or catching | ☐ Playground skills |
| ☐ Swimming and/or bowling | ☐ Playing games with others |
| ☐ Climbing and/or swinging | ☐ Interest in active living activities |
| ☐ Improved balance | ☐ Printing |
| ☐ Sensory activities (specify below) | ☐ Colouring within the lines |
| ☐ Other: _____ | |

Sensory activities: _____

If you have any questions, or need some suggestions, please contact us at: (780) 431-8443

PERSONAL DEVELOPMENT

Fill out ONLY 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: (i.e. 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: (i.e. 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: (i.e. art, computer, cooking, fitness, post-secondary, things I have never tried before, etc.)

PHYSICAL ACTIVITY READINESS (PAR) QUESTIONNAIRE

Check YES or 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 chest or heart? ☐ 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 (i.e. arthritis) that has been or may be aggravated by exercise? ☐ YES ☐ NO

6. Does the participant have any perceptual/learning/motor delays? ☐ YES ☐ NO

7. Does the individual have any allergies? ☐ YES ☐ NO

8. Are you currently taking any medication? ☐ YES ☐ NO
Please list medications on Medication Release Form.

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

Individual/Guardian/Primary Contact

Signature: Individual/Guardian/Primary Contact

Reviewed by: Employee Name

Employee Signature

MEDICAL

Physician(s)

1. Name: _____ 2. Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Alberta Health Care Number: _____

Do you have health insurance? (i.e. 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 diagnosis: _____

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, 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: _____

My Child Does Not Take Medication (signature required)

List medications administered by AdaptAbilities ONLY, including non-Prescription, over-the-counter, and herbal remedies. All medications must have a pharmacy label.

Medication Name		Return To Family
Prescription? ☐ YES ☐ NO	Administered by ☐ YES ☐ NO AdaptAbilities?	☐ Daily ☐ Weekly ☐ Monthly
Side Effects:		Times(s):
Instructions:		Dosage:

Medication Name		Return To Family
Prescription? ☐ YES ☐ NO	Administered by ☐ YES ☐ NO AdaptAbilities?	☐ Daily ☐ Weekly ☐ Monthly
Side Effects:		Times(s):
Instructions:		Dosage:

Medication Name		Return To Family
Prescription? ☐ YES ☐ NO	Administered by ☐ YES ☐ NO AdaptAbilities?	☐ Daily ☐ Weekly ☐ Monthly
Side Effects:		Times(s):
Instructions:		Dosage:

Medication Name		Return To Family
Prescription? ☐ YES ☐ NO	Administered by ☐ YES ☐ NO AdaptAbilities?	☐ Daily ☐ Weekly ☐ Monthly
Side Effects:		Times(s):
Instructions:		Dosage:

Medication Name		Return To Family
Prescription? ☐ YES ☐ NO	Administered by ☐ YES ☐ NO AdaptAbilities?	☐ Daily ☐ Weekly ☐ Monthly
Side Effects:		Times(s):
Instructions:		Dosage:

Signed this _____ day of _____, 20____, Edmonton, Alberta
expiring on August 31, 2022

Individual/Guardian/Primary Contact

Signature: Individual/Guardian/Primary Contact

Reviewed by: Employee Name

Employee Signature



ADAPTABILITIES

CREATING SUCCESS FOR LIFE

Consent Forms 2021-2022

All waivers must be signed

ASSUMPTION OF RISK

On behalf of _____, as 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 or another participant, 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 any 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, students, 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 employee 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 behaviours.

I acknowledge that I have read and understood this agreement, that I understand, appreciate, and accept the risks associated with the participant 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, 2022.

Individual/Guardian/Primary Contact

Signature: Individual/Guardian/Primary Contact

Reviewed by: Employee Name

Employee Signature

PHOTO DISCLOSURE

On behalf of _____, as parent/guardian, I

_____ understand that there are times when Alberta AdaptAbilities Association to take archival and/or promotional photos of the participants.

Alberta AdaptAbilities Association 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 Alberta AdaptAbilities Association (i.e. 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. Alberta AdaptAbilities Association will not use their photo in any manner if this were to occur.

Signed this _____ day of _____, 20____, Edmonton, Alberta
expiring August 31, 2022.

Individual/Guardian/Primary Contact

Signature: Individual/Guardian/Primary Contact

Reviewed by: Employee Name

Employee Signature

COMMUNITY ACCESS/FIELD TRIP

On behalf of _____, as 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 personal vehicle of an Alberta AdaptAbilities Association 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, that 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, 2022.

Individual/Guardian/Primary Contact

Signature: Individual/Guardian/Primary Contact

Reviewed by: Employee Name

Employee Signature

SUNSCREEN AND BUG SPRAY WAIVER

On behalf of _____, as parent/guardian, I

_____ understand that there are risks/dangers, when accessing community and participating in field trips.

AdaptAbilities employees may apply sunscreen

AdaptAbilities employees 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 and/or bug spray by Alberta AdaptAbilities Association or an employee of Alberta AdaptAbilities Association.

I acknowledge that I have read and understood this agreement, that 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 and/or bug spray to the person named above from:

Signed this _____ day of _____, 20____, Edmonton, Alberta
expiring August 31, 2022.

Individual/Guardian/Primary Contact

Signature: Individual/Guardian/Primary Contact

Reviewed by: Employee Name

Employee Signature

PICK UP RELEASE

On behalf of _____, as 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 above mentioned person(s).

I acknowledge that I have read and understood this agreement, that 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, 2022.

Individual/Guardian/Primary Contact

Signature: Individual/Guardian/Primary Contact

Reviewed by: Employee Name

Employee Signature

RELEASE OF INFORMATION

Authorization For The Release/Exchange Of Confidential Information

On behalf of _____, as 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/form/between the following agency(s), individual(s), and/or professional(s).

List Agency/Individual/Professional

AdaptAbilities

Funding Agency (Specify): _____

School/Teacher (Specify): _____

Social Worker (Specify): _____

Other (Specify): _____

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, 2022.

Individual/Guardian/Primary Contact

Signature: Individual/Guardian/Primary Contact

Reviewed by: Employee Name

Employee Signature