ADAPTABILITIES

CREATING SUCCESS FOR LIFE

Participant Profile Update 2023-2024

ABOUT ME

Please Note: Forms are in the first person.

Participant

Name: _____ _____ _____
First Name Middle Initial Last Name

Diagnosis: _____

Funder: _____ Caseworker: _____

Is a Guardianship Order in Place? ☐ YES ☐ NO

Is a Trusteeship Order in Place? ☐ YES ☐ NO

If yes, please provide a copy of the Order to AdaptAbilities.

Are you an independent adult? ☐ YES ☐ NO

If yes, please input your contact information under Guardian #1.

Guardian(s)

Guardian #1

Name: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email*: _____

Guardian #2

Name: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email*: _____

***Email addresses provided are used to create your Family Portal Account.**

Address: _____

City: _____

Postal Code: _____

Preferred Contact Number:

☐ Home ☐ Work ☐ Cell

Address: _____

City: _____

Postal Code: _____

Preferred Contact Number:

☐ Home ☐ Work ☐ Cell

Check one of the following:

☐ Parent ☐ Permanent Guardian ☐ Temporary Guardian ☐ Social Worker

☐ Other: _____

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 Interactions

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

_____

_____

Sensory Needs

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

_____

_____

Strengths

What are your strengths, interests, talents, goals? What makes you GREAT?

_____

_____

Interests – Activities That Bring Joy/Meaning To Your Life

I enjoy: _____

I do NOT enjoy: _____

I would like to try: _____

Independence

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

_____

_____

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: _____

HOW TO SUPPORT ME

AdaptAbilities believes all 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 you are upset, angry, afraid, frustrated, confused, or sad, you 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 you are upset, or start to get upset, you communicate by:

☐ None ☐ Crying ☐ Withdrawal ☐ Refusal ☐ Yelling ☐ Pouting

☐ Swearing ☐ Screaming ☐ Self-Harm ☐ Aggression ☐ Faking Injury/Illness

Explain:

_____

_____

Are there trigger and/or warning signs?

_____

_____

3. A successful environment for you looks like: (i.e. away from loud noises, less crowded, etc.)

_____

_____

4. When you are getting frustrated, it is best to support you by:

☐ 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?

_____

_____

Level of Support

Flight Risk: ☐ YES ☐ NO

If yes, please explain:_____

_____

I require a life jacket while swimming? ☐ YES ☐ NO

Swimming Notes:_____

_____

School Information (if applicable)

School: _____ Program: _____ Grade Level: ____

Number of Students in Class:_____ Teacher plus: _____ Educational Assistant(s): ____

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

Adaptive Equipment

☐ N/A ☐ Manual Wheelchair ☐ Electric Wheelchair ☐ Walker ☐ Crutches

☐ Glasses ☐ Helmet ☐ Other: _____

Personal/Self-Care

What are your personal/self-care needs?

☐ None ☐ Eating ☐ Drinking ☐ Dressing ☐ Toileting ☐ Diapers ☐ Menstrual Care

Please Explain:_____

_____

Transfer Assistance

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

STRENGTH AND GOALS

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 your strengths (i.e. 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.

Goals

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

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

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

_____ Other: _____

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

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

_____ Other: _____

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

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

_____ Other: _____

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

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 to 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: (i.e. 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.).

_____

_____

PAR QUESTIONNAIRE

Physical Activity Readiness (PAR) Questionnaire

Circle yes/no and provide explanation as required.

1. Has your doctor ever said you have heart trouble? ☐ YES ☐ NO
2. Do you frequently suffer from pains in the heart of chest? ☐ YES ☐ NO
3. Do you often feel faint or have spells of dizziness? ☐ YES ☐ NO
4. Has your doctor ever said that you have high blood pressure? ☐ YES ☐ NO
5. Has your doctor ever told you that you have a bone or joint problem (i.e. arthritis) that has been or may be aggravated by exercise? ☐ YES ☐ NO
6. Do you have any perpetual/learning/motor delays? ☐ YES ☐ NO

If yes, please specify:

_____

_____

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

_____ _____

Individual/Guardian/Primary Contact Name Individual/Guardian/Primary Contact Signature

_____ _____

Reviewed By: Employee Name Employee Signature

MEDICAL

Physician(s)

1. Name: _____ Phone: _____

   Address: _____

2. Name: _____ Phone: _____

   Address: _____

Preferred Hospital: _____ Phone: _____

Alberta Health Care #: _____

Do you have health insurance? (i.e. Blue Cross) ☐ YES ☐ NO

In the case of an emergency, AdaptAbilities will 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

Are you on insulin? ☐ YES ☐ NO

How often do you need to check your blood sugar levels?: _____

Do you need assistance? ☐ YES ☐ NO

Notes: _____

Communicable Disease: ☐ YES ☐ NO

If yes, state the diagnosis: _____

Sunscreen and Bug Spray

AdaptAbilities employees may apply **sunscreen** ☐ YES ☐ NO

AdaptAbilities employees may apply **bug spray** ☐ YES ☐ NO

Application notes:_____

_____

Frequent Health Problems

Do you take any medication at home outside of programming hours?

If yes, please list the names of the medications and side effects:

_____

_____

Are you 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:

_____

_____

Are you **unable** to participate in physical activity for any reason?

_____

_____

What intensity of physical activity is reasonable for you?

☐ Light ☐ Moderate ☐ Heavy

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

_____

_____

Special Dietary Needs

Do you use 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: ____

MEDICATION RELEASE

Participant Name: ____

Name of Parent/Guardian: ______________________________________

Medication Release form required for participants who require medications to be administered by AdaptAbilities ONLY, including non-prescription, over-the-counter, and herbal remedies. All medications must have a pharmacy label.

Medication Name		Prescription?	☐ Yes ☐ No	Return to Family
Side Effects:		Time(s):		☐ Daily ☐ Weekly ☐ Monthly
Instructions:		Dosage:		
Medication Name		Prescription?	☐ Yes ☐ No	Return to Family
Side Effects:		Time(s):		☐ Daily ☐ Weekly ☐ Monthly
Instructions:		Dosage:		
Medication Name		Prescription?	☐ Yes ☐ No	Return to Family
Side Effects:		Time(s):		☐ Daily ☐ Weekly ☐ Monthly
Instructions:		Dosage:		
Medication Name		Prescription?	☐ Yes ☐ No	Return to Family
Side Effects:		Time(s):		☐ Daily ☐ Weekly ☐ Monthly
Instructions:		Dosage:		
Medication Name		Prescription?	☐ Yes ☐ No	Return to Family
Side Effects:		Time(s):		☐ Daily ☐ Weekly ☐ Monthly
Instructions:		Dosage:		

Signed this ______ day of _________________________, 20______, Edmonton Alberta expiring August 31, 2024.

_________________________________ _________________________________

Individual/Guardian/Primary Contact Name Individual/Guardian/Primary Contact Signature

Reviewed By: Employee Name Employee Signature

TRANSPORTATION

AdaptAbilities does not provide transportation to access our centre programs.

If applicable, which transportation service do you use to access our programs?

School Age (School Bus)	Adult (DATS)
Bus Company:_____ Phone #: _____Bus #:_____	DATS #: _____

PICKUP RELEASE

Persons not listed on the Pickup Release will be requested to provide a photo identification and will require authorization from a parent/guardian prior to release of the participant.

	Name (In Full)	Day/Date(s)	Notes
1.			
2.			
3.			

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 understand that I can change and update the information via the AdaptAbilities Family Portal at any time.

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

Individual/Parent/Guardian Signature Date

ADAPTABILITIES

CREATING SUCCESS FOR LIFE

Consent Forms 2023-2024

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, 2024.

_____ _____

Individual/Guardian/Primary Contact | Individual/Guardian/Primary Contact Signature

_____ _____

Reviewed by: Employee Name | Employee Signature

PHOTO DISCLOSURE

On behalf of _____, as a parent/guardian, I

_____ understand that there are times when Alberta AdaptAbilities Association will 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 box for photo disclosure of pictures taken:

☐ 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 will not use their photo in any manner if this were to occur.

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

_____ _____
Individual/Guardian/Primary Contact Name Individual/Guardian/Primary Contact Signature

_____ _____
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, 2024.

_____ _____

Individual/Guardian/Primary Contact | Individual/Guardian/Primary Contact Signature

_____ _____

Reviewed by: Employee Name | Employee Signature