

WHO IS FILLING OUT THIS REGISTRATION FORM?

Date received (office use only)

Name(s): _____

AS PER NAMES INDICATED ABOVE, PLEASE CHECK ALL THAT APPLY BELOW AND INDICATE RELATION TO APPLICANT.

Family member residing with child or youth some and/or all of the time:

- Full custody: _____ Shared custody: _____ Adoptive parent with custody: _____
- Grandparent/Sibling/Other Relative living in same residence: _____
- Foster parent currently residing with child or youth (i.e. non-guardian): _____

 Family member not currently residing with child/youth (i.e. grandparent, sibling, other relative): _____

Teacher, EA, School personnel OR Clinical representative (i.e. OT, PT, SLP, Behavioural specialist, Physician, etc.):

Name & Role: _____

Other (specify): _____ Role: _____

(i.e. Social worker/Agency representative/Recreational coordinator/CAS guardian/ Respite provider/ Care home)

Has the PRIMARY caregiver to applicant, and child or youth (as applicable) been consulted around this registration, and given consent for Reach for the Rainbow to proceed with a recreational placement?

- Yes No

For which year is placement FIRST being considered? (Child must be at least turning five years old by the onset/year of their program)

1st choice: 2 0 ____ 2nd choice: 2 0 ____ 3rd choice: 2 0 ____

Note: Once intake is complete this participant's name, contact information provided, and other relevant contents will be shared with a partnered community facility or summer camp discussed as an option. Once confirmed, CANCELLATIONS are difficult to resolve as much investment has gone into preparing for a participant's upcoming experience and another child or youth may not be able to fill that same space due to time constraints. For everyone's benefit we ask for your commitment and for payment due according to either the year-round schedule as applicable, or in the case of summer camp by June 1st of the same season. If you have an alternate funding source, their name and contact information must be provided to RFTR.

I acknowledge that the primary caregiver and child/youth (as applicable) have been consulted around completion of this registration form for an integrated recreational program placement through Reach for the Rainbow.

Print Name: _____ Signature: _____ Date: _____

New Participant Registration

Please send a recent photo

First Name: _____ Last Name: _____

Nickname (preferred name): _____ Male Female

Date of Birth: ____ / ____ / ____ Age: ____ Height: ____ Weight: ____
DAY MONTH YEAR

Parent/Guardian(s):

Mothers Name		Fathers Name			Home Phone
Address		Apt #	Email Address 1	Regular access to email? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent 1's Cell Phone
City	Province	Postal Code	Email Address 2	Regular access to email? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent 2's Cell Phone
Parent 1's Place of Employment:				May we contact you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Name: _____	
				Business Number: _____	
Parent 2's Place of Employment:				May we contact you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Name: _____	
				Business Number: _____	
Summer emergency contact (alternate to above)			Summer emergency contact telephone (alternate to above)		

If divorced or separated, please indicate who has legal custody: _____

Sibling(s)	Age(s)	Will attend camp together?	Will attend through RFTR?
_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A
_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A
_____	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A

Language(s) spoken at home: _____

Please select program(s) that interest you

DAY CAMP

Durham, Halton, Hamilton/Burlington/Brantford, Peel, Toronto & York Region

Preferred Dates: July August

RESIDENTIAL CAMP

Overnight locations across Ontario

Preferred Dates: July August

YEAR-ROUND PROGRAM

(Certain select areas within the GTA & Hamilton for children & teens; weeknight & weekend supported swimming lessons, athletics, and trampoline program)

Preferred Location(s): Southwestern Ontario Muskoka Haliburton Sudbury-Sault Ste. Marie Eastern Ontario Hamilton-Niagara

Please note all program spaces are available on a first come, first served basis, with age, gender, and theme criteria.

Be sure to get your registration form in soon! Spaces are limited for those 14 years and older.

Indicate how the applicant's family heard about Reach for the Rainbow? _____

Strengths & Needs

To attend camp with 1:1 support through Reach for the Rainbow, applicants must have a documented developmental and/or physical disability which affects day-to-day functioning. A.D.D., A.D.H.D., L.D. alone, do not constitute eligibility.

Please check all that are applicable:

- | | | | | |
|---|--|--|--|---|
| <input type="checkbox"/> Developmental disability | <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Communication disorder | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Downs Syndrome | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Visual impairment | <input type="checkbox"/> ADD or ADHD |
| <input type="checkbox"/> Tourette's Syndrome | <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Asthma/respiratory problems | <input type="checkbox"/> Fetal Alcohol Syndrome (FAS) | |
| <input type="checkbox"/> Fragile X Syndrome | <input type="checkbox"/> Acquired Brain Injury | <input type="checkbox"/> Tuberos Sclerosis | <input type="checkbox"/> Skin Condition (specify): _____ | |
| <input type="checkbox"/> ASD (Autism, Pervasive developmental disorder; PDD N.O.S.; Asperger's) | | <input type="checkbox"/> Other (specify): _____ | | |

Does your child use/have any of the following? Check all that apply.

- | | | | | | | |
|-------------------------------------|---|-----------------------------------|--|---|-------------------------------------|---|
| <input type="checkbox"/> wheelchair | <input type="checkbox"/> walking stick/cane | <input type="checkbox"/> walker | <input type="checkbox"/> tubes (in ears) | <input type="checkbox"/> hearing aid | <input type="checkbox"/> earplugs | <input type="checkbox"/> orthotics (shoe, ankle, leg) |
| <input type="checkbox"/> shunt | <input type="checkbox"/> G-tube | <input type="checkbox"/> catheter | <input type="checkbox"/> inhaler | <input type="checkbox"/> eye glasses/contact lenses | <input type="checkbox"/> terra trek | <input type="checkbox"/> jogger |
| <input type="checkbox"/> prosthesis | <input type="checkbox"/> dental device | <input type="checkbox"/> Epi-pen | <input type="checkbox"/> sleep apnea machine | <input type="checkbox"/> Other: (specify) _____ | | |

List ALL allergies (dietary AND environmental). Please describe reaction and management of reaction, including remedy.

Do you receive funding? Indicate all funding sources received:

Assistance for Children with Severe Disabilities (ACSD)? Y N Special Services At Home (SSAH)? Y N

Other funding sources? (e.g.s President's Choice, Jennifer Ashleigh, Community Living etc.) Y N

If so, list all: _____

If no, please explain (i.e. on waitlist): _____

Highlight strengths and abilities:

Describe the area(s) in which they require the most support or assistance, e.g. social, mobility, self-care, communication

Current medication regime*

Prescription Medication(s)	Dosage	Time(s)	Purpose
Non-Prescription Medications			

***Please inform Reach for the Rainbow IMMEDIATELY of any changes to diagnosis, health, or medication. If you are visiting the family doctor and imminent changes appear warranted, note that it is recommended that participant is well-stabilized PRIOR TO camp time. This eases their adjustment and allows for a more successful experience. Thank you!**

Physician Name: _____ Telephone: _____ Email: _____

Neurologist Name: _____ Telephone: _____ Email: _____

Other Specialist: _____ Telephone: _____ Email: _____

Hospital Affiliation: _____ Telephone: _____ Email: _____

Communication & Interpersonal Development

How does your child communicate? Check all that apply.

functional speech gestures picture/photo book leading/pointing sign language picture-symbols

isolated sounds/words picture exchange program (PECS) communication device (specify): _____

Please describe both expressive & receptive communication skills:

Communication Consultant/Agency: _____ Speech Therapist Name: _____

Telephone: _____ Email: _____

In social settings, when does your child experience the most difficulty? Please explain (e.g. crowds, transitions, change, and general interactions). How do you respond?

List sensory considerations (e.g. noise, taste, smell, visual, mobility, balance, constant movement, touch, deep pressure) and how best to respond:

List potential problems for your child at camp (e.g. wandering, water, fears) and how would you respond?

Return to Reach for the Rainbow, 20 Torlake Crescent, Toronto ON M8Z 1B3

Tel: 416-503-0088 Email: info@reachfortherainbow.ca Fax: 416-503-0485 www.reachfortherainbow.ca

List behavioural/social difficulties (e.g. tantrums, verbal or physical exchanges, repetitive behaviour) and how would you respond?

Behavioural Consultant Name: _____ Telephone: _____ Email: _____

Which skill/leisure program(s) does your child participate in during the year?

Camp/Leisure Program	Year(s)	Highlights	Difficulties

Describe your child's swimming abilities/badge level.

Favourite activities:

Least favourite activities:

Daily Living

Check all that apply.

- fully toilet trained (urination & BM) partially toilet trained (urination BM) wears regular underwear
- wears diapers/pull-ups: during day when sleeping experiences enuresis (bed-wetting)
- experiences wetting accident (day-time)

Does he/she have difficulty settling or sleeping at night? YES NO Sleep Apnea? YES NO

Describe the nighttime routine that helps to calm or settle your child. Do they wake during the night? How often?

Describe the guidance/assistance needed at meal times. Include any special dietary needs.

Outside Information

School: _____ Classroom Type (i.e. integrated, specialized): _____

Teacher: _____ Telephone: _____ Email: _____

EA (if applicable): _____ Telephone: _____ Email: _____

May we contact the teacher or teacher's aide for additional information? YES NO

School Clinician's Name: _____ Telephone: _____ Email: _____

May we contact the clinician/therapist for additional information? YES NO

Social worker/Agency representative/Service coordinator Name: _____ Role: _____

Agency/Organization: _____ Telephone: _____ Email: _____

May we contact the social worker/agency rep. /service coordinator for additional information? YES NO

***Please enclose a copy of a recent school report, IEP, therapy or diagnostic reports, and/or Personal Goals Report. Health and RFTR Consent Forms must be sent to Reach for the Rainbow prior to program's start.**

Additional Comments

Please include anything else that would be helpful to know about your child.
