

Registration

To best serve the needs of participants, we require the following information to be complete for all participants with medical or special needs.

Participant's Family Name _____ First Name _____ Home Phone # _____

Birth Date:
 M _____ D _____ Y _____
 (If under 18 years of age)

Please complete the following questions if applicable:

1 Allergies:
 Participant has non-life-threatening allergies: Please identify: _____

 Participant has life-threatening allergies:
 Please note that for participants in this category a Medic-Alert or similar identification bracelet/necklace is recommended.
 Peanut Allergy Does participant carry an Epi-Pen? Yes No
 Bee Sting Allergy Does participant carry an Epi-Pen? Yes No
 Other Severe Allergy: _____ Does participant carry an Epi-Pen? Yes No

2 Asthma: Yes No Does participant carry inhaler/ventilator: Yes No

3 Behavioural Conditions: (please circle one and answer yes or no below)
 ADD ADHD
 Is extra support/assistance required for basic care? Yes No
 Does disability affect the safety of the participant? Yes No
 Does your child take any prescribed medications? Yes No

 If yes, please list: _____

4 Impairment: (please check if applicable)
 Visual Impairment Hearing Impairment

 Physical impairment (describe condition and whether assistance is required for basic care).

 Developmental Delay (describe condition and whether assistance is required for basic care).

 Does the participant require support with basic needs:
 Dressing Toileting Feeding Other _____
 If other, explain: _____

5 Conditions: (please check if applicable)
 Seizure Disorder Cardiac Other _____
 Other Special Considerations: _____
 Does the participant take any prescribed medication? If yes please specify: _____

The purpose of this participant profile is to provide the participant with appropriate care. This profile will be kept in confidence with essential administrative staff when the participant is in our care for more than two consecutive hours. If special circumstances apply parents/guardians are required to speak directly to on site program staff.

Parent/Guardian Signature: _____ Date: _____

The personal information on this form is collected under the authority of the Municipal Act, SO 2001, c.25, and will be used for the purpose of seeking medical assistance for the participant. Questions about the collection of personal information should be directed to the City of Brampton, Community Services Department at 905-874-2300