



PLEASE PRINT

INCLUSION SUPPORT APPLICATION

Inclusion Support & Deadlines

SECTION 1

The City of St. John's recognizes the need for support services to assist participation in recreation and leisure programming. To request support to participate please submit completed applications by the deadline dates below. Deadline dates occurring on a weekend are extended to the following Monday.

Programs	Deadline
Spring Recreation Programs	February 1
After School Programs	March 1
Summer Recreation Programs	March 17
Fall Recreation Programs	July 17
Winter Recreation Programs	November 17

Participant Information

SECTION 2

Participant Name: _____ Gender: _____ Age: _____
 Address: _____ Date of Birth: _____
 City/Town: _____ Phone: _____
 Postal Code: _____ Email: _____

Guardian Information (if participant is less than 19 years)

SECTION 3

Guardian 1: _____ Guardian 2: _____
 Relation to Participant: _____ Relation to Participant: _____
 Phone: _____ Phone: _____
 Email: _____ Email: _____

Program Information

SECTION 4

Program Name*: _____
 Program Location: _____
 Enrollment Dates: _____

* If program name is not known, indicate the program type. E.g. Fitness Class, After School Care, Day Camp, Preschool, Older Adults Program, etc.

PLEASE COMPLETE ALL PAGES



NEWFOUNDLAND AND LABRADOR, CANADA

Medical Information (check all applicable information)

SECTION 5

- Primary Diagnosis: _____
 - Medication required to regulate symptoms: _____
 - Medication administered: at home at program (Medication Consent required)
 - Medication causes side effects: _____

- Secondary Relevant Diagnosis: _____
 - Medication required to regulate symptoms: _____
 - Medication administered: at home at program (Medication Consent required)
 - Medication causes side effects: _____

- Allergies: _____
 - Life threatening - Epinephrine Auto-Injector required (Anaphylaxis Emergency Plan required)
 - Other medication administered: at home at program (Medication Consent required)
 - Medication causes side effects: _____

- Seizures (Seizure Plan required)
 - Date of last seizure: _____ Duration of last seizure: _____
 - Medication required to regulate symptoms: _____
 - Medication administered: at home at program (Medication Consent required)
 - Medication causes side effects: _____


Support Information

SECTION 6

Please indicate the **anticipated** level of support. If applicable, actual level of support provided will be determined through a review of all information gathered through an intake process.

- Assistance with program information and selection
- Minor adaptations or accommodations
- Staff Support – **See the next page for staffing support descriptions**
 - General recreation staff
 - Recreation program support staff (summer only)
 - Low ratio inclusion staff
 - One on one inclusion staff
 - Respite staff (provided independently)
- Unsure of the type of support needed at this time

STAFFING SUPPORT DESCRIPTION

<p>Lower Needs</p>  <p>Higher Needs</p>	<p>General Recreation Staff Support Needs may be met by recreation staff to participant ratios. Preschool programs = 1:8 School age programs = 1:10 Adults = Not Applicable</p> <p>Recreation Program Support Staff (Children’s Summer Program Only) Needs may be met by an additional program staff who provides occasional/intermittent support to the program and participants as required.</p> <p>Low Ratio Inclusion Staff Support Needs may be met by a shared inclusion staff who provides support to 2 participants having similar needs. (Does not include personal care, feeding or persistent, extreme behavior)</p> <p>One on One Inclusion Staff Support Needs require the attention of a City of St. John’s Inclusion Staff who provides support to one participant. (Does not include personal care, feeding or persistent, extreme behavior)</p> <p>Respite Staff Support Participant has high level of needs which are required to be met by a staff person hired by the caregiver. A Support Worker Agreement is required.</p>
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Please note: The Recreation Division requires all participants adhere to the Code of Conduct. Participants who do not adhere may be removed on a part-time or full time basis at the discretion of Staff. Participants requiring support with personal care, feeding needs or persistent extreme behavioral needs may participate with a Respite Staff hired by the family or a third party.

Support in Other Settings - Please check all support types currently in place

- | | |
|---|---|
| <input type="checkbox"/> Respite/Support worker at home | <input type="checkbox"/> One on One Student Assistant at school |
| <input type="checkbox"/> ABA Therapy | <input type="checkbox"/> Shared Student Assistant at school |
| <input type="checkbox"/> Behavior Management Specialist | <input type="checkbox"/> General Academic Curriculum |
| <input type="checkbox"/> Speech Language Pathology | <input type="checkbox"/> Modified/Alternate Academic Curriculum |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> School Name: _____ |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Grade: _____ |

Ability Survey (check items that describe participant ability)

SECTION 7

Swim Ability

- Swims independently
- Swims with floatation device
- Swim Lesson Level: _____
- No previous swim experience

Additional Information:

Personal Care

- Eats and drinks independently
- Eats and drinks with assistance
- Washes hands independently
- Washes hands with assistance
- Uses toilet independently
- Uses toilet with assistance
- Dresses independently
- Dresses with assistance

Additional Information:

Communication

- Can communicate needs/wants verbally
- Limited verbal communication of needs/wants
- Uses complete sentences
- Does not use complete sentences
- Uses partial sentences
- Uses some words with prompts
- Uses sign language
- Uses a communication device (specify below)

Additional Information:

Strength/Coordination

- Good fine motor skills
- Limited fine motor skills
- Good gross motor skills
- Limited gross motor skills

Additional Information:

Interactions

- | | |
|--|---|
| <input type="checkbox"/> Generally displays good social skills | <input type="checkbox"/> May present limited social skills |
| <input type="checkbox"/> Generally respectful of peers | <input type="checkbox"/> May be disrespectful of peers |
| <input type="checkbox"/> Generally respectful of adults | <input type="checkbox"/> May be disrespectful of adults |
| <input type="checkbox"/> Generally tolerant of others | <input type="checkbox"/> May be easily annoyed/agitated by others |
| <input type="checkbox"/> Generally follows rules | <input type="checkbox"/> May not adhere to rules |
| <input type="checkbox"/> Generally does well in group settings | <input type="checkbox"/> May prefer to be alone |
| <input type="checkbox"/> Generally stays within supervision | <input type="checkbox"/> May wander/leave program area |
| <input type="checkbox"/> Generally well-mannered | <input type="checkbox"/> May be verbally aggressive |
| <input type="checkbox"/> Generally calm | <input type="checkbox"/> May be physically aggressive |
| <input type="checkbox"/> Generally displays good coping skills | <input type="checkbox"/> May not display effective coping skills |

Additional Information:

Strengths – Describe the participant’s strengths

Needs – Describe what the participant needs to participate

Safety – Describe concerns regarding safety

Stress – Describe what causes the participant to become anxious/stressed

Behavior – Describe techniques used that reduce or eliminate unwanted behavior

Other – Describe any other information which may increase success at the program

Consent

SECTION 8

I _____ (Participant/Guardian) believe that the information provided in this document is accurate and true to the best of my knowledge. I give permission for those authorized below to release information if requested by the Division of Recreation’s Inclusive Services Staff in order to develop a support plan to assist me/my child in participating in inclusive recreation programs.

At **least one** professional reference who can provide additional information to support participation is required. Please provide information for those authorized to be contacted.

Reference/Name	Preferred Method of Contact (I.e. Phone or Email)
<input type="checkbox"/> School/Daycare Teacher:	
<input type="checkbox"/> Special Education Teacher:	
<input type="checkbox"/> Social Worker:	
<input type="checkbox"/> Senior ABA Therapist:	
<input type="checkbox"/> Behavior Management Specialist:	
<input type="checkbox"/> Recreation Practitioner:	
<input type="checkbox"/> Other:	

Participant/Guardian Signature: _____ **Date:** _____

Privacy Notice

SECTION 9

Collection of personal information via this form is authorized under the Access to Information and Protection of Privacy Act, 2015 and is needed to provide care to participants. Questions about the collection and use of the information may be directed to Manager of Family & Leisure Services at 576-8020 or email inclusion@stjohns.ca

<p>Please return completed forms to:</p> <p>Inclusive Services City of St. John’s Recreation Division P.O. Box 908 St. John’s, NL A1C 5M2</p>	<p>For further information: Phone: (709) 576-4450 Fax: (709) 576-2308 Email: inclusion@stjohns.ca</p>
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