City of Kingston Recreation & Leisure Services
For general registration inquiries call 613-546-4291 ext. 1700
Please return completed form to the Integration Coordinator:
Drop off: Artillery Park Aquatic Centre, Attention: Inclusion Coordinator

Adapted/Integrated Information Form – Ages 6 – 12 yrs.

For Special Needs/Medication Administration

Personal Information

Every effort is made to provide support to children with special needs either through staff, adaptive equipment and/or the use of volunteers. The City may be required to limit the hours of support based on available resources. Priority is given to residents.

Please complete form noting the child's needs and behaviors. Some children may require additional support to overcome certain barriers to their participation. Where a child's behavior endangers themselves or others, or compromises the program experience of other children, may be removed from the program at the program supervisor's discretion. Program refunds will be prorated from the first full day of absence as per the refund policy.

Participants are responsible for their own self-care needs (transportation, medication, toileting and feeding). Those who require assistance with self-care needs must provide their own one-to one support person to assist them.

Participants with special needs will attend program with support worker
☐ Yes ☐ No

Case Manager::_____

Contact Number:
_____

Agency/ Organization:
_____

Support Worker Name:
_____

Support Worker Contact:
_____

Participants Last Name:	**Participants First Name:**	**Birth Date:**
Address:	**Home Phone:**	**Emergency Contact (Name & Contact Number):**
Preferred Hospital:	**Health Card Number:**	**Date received**

Program Information/Assessment

Recreation Program Title Requested:	**Time:**	**Session Date:**

Office Use Only

Integration Forms sent to client:	☐ **Yes** ☐ **No**
Date forms sent to client	**Day/month/year**
Integration Forms submitted by client	☐ **Yes** ☐ **No**
Meeting scheduled with Client and/or participant	☐ **Yes** ☐ **No**
Date of meeting:	**Day/month/year**
Time of meeting	
Meeting completed	☐ **Yes** ☐ **No**
Documentation complete and on file	☐ **Yes** ☐ **No**

Purpose of program

Purpose		**Comments**
As stepping stone to integration/inclusion	☐	
As re-entry into community after rehabilitation	☐	
As an alternative to full integration & to foster friendships and interact socially	☐	
To gain confidence and develop specific skills	☐	

Accommodation Requirements	
Will attend program independently	☐ **Yes** ☐ **No**
Program support is required	☐ **Yes** ☐ **No**
Support person details. Please specify: Relationship:	**Name:**
	Contact #:
	Agency (if applicable):

Accommodation Request

Special requirements :	☐ **Yes** ☐ **No**	**Comments:**

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The following accommodation information to be completed in consultation with the Inclusion Coordinator:		
Accessibility of Program Location:	☐	**Comments:**
Reasonable Accommodation Requests (see definition)	☐ **Yes** ☐ **No**	**Requests:**

For Special Needs/Medication Administration

1. **Medication Administration Request** ☐ yes ☐ No
If yes, the following forms must be completed:
- ☐ Terms and Conditions for Recreation and Leisure Services Department staff to supervise the administration administer or store the participant medication.

NOTE: If participant under the age of 13, *Medication Administration Request Form* to be completed. Medication shall be self-administered by any participant 13 years of age and older with the exception of life-threatening allergy medication

2. **Physical mobility, mental challenges or behaviors**
Medical diagnosis: ☐ Down Syndrome ☐ Autism ☐ Acquired Brain Injury ☐ Other:
_____
☐ Physical challenges:
_____
☐ Mental challenges:
_____
☐ Behaviors:
_____

3. **Vision, hearing or physical impairment/restriction**
☐ Vision ☐ Hearing ☐ Physical impairment/restriction Please describe:
_____

4. **Helpful information**
Is extra support required at school/work? ☐ Yes ☐ No

Does the disability affect the safety of the participant? Or other participants?
☐ Yes ☐ No Details: _____

Is extra support/assistance required for integration/participation in this program? ☐ Yes ☐ No

Is the participant currently associated with a support agency? ☐ Yes ☐ No Agency:
_____

5. **Tips for Staff: (Please also use back of sheet if needed)**

6. **Participant Signature:**
(or guardian if participant under age of 18): _____
Date_____

Personal Information, as defined by the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA), including (but not limited to), names, addresses, medical/physical concerns, is collected under the authority of the Municipal Act 2001, and in accordance with MFIPPA, and all other relevant legislation. All personal information may be used for class lists and lesson plans, as well as to form statistical lists and /or reports, and therefore will be made available to Instructor staff and the City Clerk's Department, 216 Ontario Street, Kingston. Ontario. K7L 2Z3.