west toronto
KEYS
to INclusion
westtorontokeys.com
keystoinclusion@gmail.com

Participant Information Form

Date: _____

Name: _____

Date of Birth: _____

Address: _____

Phone: _____ **Cell:** _____

Email: _____

Parent's Names: _____

Address: _____

Phone: _____**Cell:** _____

Work phone:_____

Email: _____

Emergency contacts:

Name: _____ **Phone:** _____
Relationship to participant: _____

Name: _____ **Phone:** _____
Relationship to participant: _____

A. MEDICAL:

Diagnoses: _____

Health Card #: _____

Physician(s) Names and Phone Numbers:

Please describe any medical and/or mental health needs:

_____
_____
_____
_____
_____
_____

Medications:

_____
_____
_____

Dietary Needs/Restrictions:

_____
_____

Allergies: _____
_____

Epipen: Yes____ No ___
If Yes, please describe when it should be administered, procedure etc.

_____
_____

Seizures: Yes ___ No ___
If Yes, please describe protocol.

_____
_____
_____

B. <u>LIVING SITUATION</u>:
Who does this person live with?

_____
_____

Family members and involvement with this person:

_____
_____

_____
_____

Does this person have a Support Circle? _____

Does this person have a Life Plan? _____
If yes, please include a copy.

If no, please describe some goals and aspirations of this person:

_____
_____
_____

Describe activities for which this person needs physical assistance:

_____
_____
_____
_____

Does this person have any physical, emotional, sensory or other limitations that will affect their ability to participate in the program? _____
_____
_____

C. <u>COMMUNITY</u>:
How does this person get around in the community? _____
_____

Is learning how to use the TTC independently a goal? _____

Does this person work or do volunteer work? _____
If yes, please describe:

_____
_____
_____
_____

Please list involvement in other community programs (social, recreational, work training, place of worship etc):

_____
_____
_____

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Does this person read? _____ If yes, at what level?_____

_____

Does this person write? _____ If yes, at what level? _____

_____

Is ongoing literacy development a goal? _____

Which day(s) would this person attend?

_____

How will this person get to and from KEYS? _____

_____

_____

Can this person leave from KEYS independently?

_____

Please list names and contact phone #s of any persons involved in assisting this person to get to and from KEYS:

_____

_____

_____

ANY OTHER COMMENTS:

THANK YOU !