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| **PARTICIPANT INFORMATION (18-35 years of age can apply)** |
| First Name Middle Initial(s): Last Name: |
| Address: City: |
| Postal Code: Home Phone: Health Card: |
| Date of Birth (Month/Day/Year): / / Gender M/F/Other: |

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| **CONTACT INFORMATION** | |
| Parent/Guardian’s Name:    **\*Please note if you will be out of area the week the participant requests to attend and verify your emergency contact will be available in case of emergency\*** | |
| Home Phone: Work Phone: Cell Phone: | |
| Address: | |
| City | Email: |

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| Have you attended LRP before? Circle yes or no If yes what year(s) did you attend?  Please select which week you are interested in attending: (preference/spot is not guaranteed)  Week 1: July 4-8 Week 2: July 11-15 Week 3: July 18-22 Week 4: July 25-29  \*Only one week is available per person, please check off any week you are available\* |

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| **ALTERNATE EMERGENCY CONTACT #1** |
| Primary Contact: |
| Phone #’s: / / |
| Relationship to Participant: |
| Address: |

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| **ALTERNATE EMERGENCY CONTACT #2** |
| Secondary Contact: |
| Phone #’s: / / |
| Relationship to Participant: |
| Address: |
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| **HEALTH INFORMATION** |
| Primary Diagnosis and Brief Description: |
| Other Conditions/Health Information: |
| Allergies (please list all food, medication, etc...): |
| Do you require the use of an epi-pen: ⁭ Yes ⁭ No |
| Do you take any medications currently? Circle ⁭ Yes or ⁭ No  Do you self-administer your medication? Circle ⁭ Yes or ⁭ No  🗖I need prompting that it is time to take my medication  🗖 I need complete assistance in taking my medication  Do you require staff to administer medication? Circle ⁭ Yes or ⁭ No  (If yes, you will be required to sign the CONSENT FOR MEDICATION ADMINSTATION FORM)  Please list all medications by name/dosage/route and administration times: If you take your medication with something other than water, please indicate preference and bring this with medication.   |  |  |  |  | | --- | --- | --- | --- | | Name of medication: | Route/location on body | Dosage/amount | Time: 9am/12pm/4pm? | |  |  |  |  | |  |  |  |  | |  |  |  |  | |

THE PARTICIPATION HOUSE PROJECT (DURHAM REGION) CONSENT FOR MEDICATION ADMINSTATION (July 2022)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Participant/Guardian Name), hereby give consent to The Participation House Project (Durham Region) (PH) to administer personal

Medications to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Participants Name) while accessing the Life Readiness Program hosted by PH.

I also understand that if \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Participants Name) refuses any medication or there is a medication discrepancy, that The Participation House Project (Durham Region) cannot be responsible for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_’s (Participants Name) medical safety or behavior.

I understand that should I choose; I have the right to revoke my consent at any time.

This consent is to be effective during a period (not to exceed a four-week period) from the date of this release.

Date (yy/mm/dd) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective to (yy/mm/dd): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness’ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **COMMUNICATION** |
| Do you wear hearing aids: Circle Yes or No |
| Do you have speech difficulties: Yes or No |
| IF you answered yes to either of the above questions, please explain and indicate how you communicate: |

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| **SOCIAL DEVELOPMENT** |
| **It is imperative that this section is filled out accurately so that we can provide the support required to make this a successful experience for all participants. LRP support ratio is 1:4 (1 staff to every 6 participants) support level.** |
| **Choose an option below that best describes your social interaction style:**  🗖Independently interacts with others without support.  🗖Requires encouragement and minimal support when getting involved in new experiences.  🗖Requires complete support engaging and actively participating in social situations. |
| **Choose an option below that best describes your decision-making abilities:**  🗖Independent  🗖Requires prompting🗖Requires complete support during the day |
| **Choose one of the following statements to describe how you react to situations that may cause increased anxiety…**  🗖When I am anxious or upset, I can remove myself from the situation and use coping mechanisms to relax.  🗖When I am anxious or upset, I will direct my anger at my environment through physical aggression.  🗖When I am anxious or upset, I will run off and not tell you where I am going.  🗖When I am anxious or upset, I may hurt myself.  🗖When I am anxious or upset, I will direct my anger at another person through verbal aggression.  🗖When I am anxious or upset, I will direct my anger at another person through physical aggression |
| I experience these types of situations...  🗖daily 🗖 weekly 🗖monthly 🗖yearly |
| **Alcohol Consumption:** In a supported environment (at a restaurant) do you grant permission for the participant to have one alcoholic beverage if they choose: **YES or NO**  Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **CARE PROVISIONS** |
| Do you have any special dietary needs or restrictions? 🗖 yes 🗖no  Please explain in detail:  (We would like to remind families who are filling out this portion that people attending are on vacation, working on developing their independence skills, healthy choices will be discussed and recommended however, the ultimate choice is that of the participant). |
| Please indicate the level of assistance required for each of the following activities  Total Assistance Some Assistance No Assistance  Eating 🗖 🗖 🗖  Washing Hands/Face 🗖 🗖 🗖  Toileting 🗖 🗖 🗖 |
| Do you use a mobility device and require assistance with transferring? 🗖 yes 🗖no  If you answered yes, please describe the level of support required. Please be specific: |
| When completing your personal care (using washroom facilities or personal absorbency products) do you require assistance? 🗖 yes 🗖no  Please explain in detail: |
| Are there any other specialized equipment/services you require that have not been mentioned?  **\*If a lift is required, please specify on this application so we can ensure proper supports are in place.**  🗖 yes 🗖no  If yes, please specify: |

Have you completed your application and SIS (Support Intensity Scale) assessment though the DSO (Developmental Services Ontario)?

(Please circle your response) **Yes** or **No**

If yes, please include a copy of the SIS assessment in with this application if you are new applicant.

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| **TRANSPORTATION** |
| Participants or their families must arrange transportation for the participant to get to the location. While accessing the community during the day, participants will be utilizing public transit, with staff support. **Do not** purchase bus passes for the week as they will be supplied while attending the program. |

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| PERSONAL FINANCES:  I AM IN CHARGE OF MY SPENDING MONEY AND HOLD IT ON ME IN MY WALLET. WHILE AT PARTICIPATION HOUSE PROGRAM –LRP. STAFF ARE NOT LIABLE FOR MY MONEY OR MISSING BELONGINGS.  CIRCLE: AGREE? YES OR NO |

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| **PROGRAM FEES** |
| Included in the program fee will be the cost of transportation, and meals lunch and snacks for the program. Payment of $400.00 is required through e-transfer. E-transfer information will be sent after you are **notified as accepted** into the program.   * **A $50.00 cancellation fee will be charged in the event of a cancellation.** * **A program space is only secured once payment is received and after email acceptance has occurred.** * **Participants are required to bring $100 cash in (small bills) for the purpose of *learning to budget for recreational activities and participation*** |

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| Please indicate if you are receiving Summer Respite Support from any of the listed Agencies:  o Christian Horizons o Community Living Ajax Pickering  o Durham Association for Family Respite o Kerry’s Place  o Community Living Durham North o Community Living (CLOC)  o Other: |

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| **SIGNATURE** |

**Please note full completion of this application is required to determine an applicant’s eligibility to participate in The Life Readiness Program. The Participation House Project (Durham Region) reserves the right to refuse any applicant who has submitted an incomplete or falsified application. This may also include sending home a participant who is presenting with support needs greater than indicated on the application and that are beyond the program’s ability to safely accommodate.**

**The undersigned verifies that the information given in this application is complete and accurate to the best of his/her knowledge.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Applicant**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Parent/Guardian**

Due to Covid-19 we are working remotely, contact is best via email. **Please E-mail (e-mail only) Application to:**Andrea Andrus - Email: [aandrus@phdurham.com](mailto:aandrus@phdurham.com)

Manager - Community Services and Partnerships

The Participation House Project (Durham Region)

\*\*Submitting an application does not guarantee acceptance\*\*   
\*\***APPLICATION DEADLINE:** June 3, 2022\*\*  
  
  
Hope to see you at Life Readiness 2022!   
Let’s have some fun!