

Registrant (Child) Name (please print: last, first): \_\_\_\_\_  
FOR OFFICE USE ONLY: Date Received: \_\_\_\_\_ Form #: \_\_\_\_\_

## Spiral Garden Summer 2023 Program Registration

We are pleased to offer Spiral Garden, an integrated outdoor art, play, music and garden program for all children. The program activities, site and staffing model are designed to be inclusive so all children can participate successfully. Support can be provided for a set number of children who need support around activities of daily living, medication routines, mobility and self-regulation.

Once again, Spiral Garden is expected to be subject to the provincial guidelines for summer day camps, which are not yet available. Despite our best effort to predict what to expect for this summer, please note that the program details outlined below are conditional on the provincial guidelines that may result in modifications to the program structure and/or operations.

Additionally, there may be construction adjacent to Spiral Garden this summer. Please expect related construction noise, machinery and dust etc.

1. Participants must be between 6 – 18 years of age.
2. The program will be offered in-person, on-site for two-week sessions\*
3. Spiral Garden will be offering full-day programming from 9:00am – 4:00pm
4. For participant supports requiring an increased level of support:
  - Support will be provided by Holland Bloorview staff and/or volunteers, based on availability
  - Family-provided support may be accommodated, if possible.
  - Registration will happen on a first come first served basis. We will also hold a limited number of spots for registrations received after April 1<sup>st</sup> that will be allocated by lottery on May 15<sup>th</sup>
5. Registration is open to all children with and without special needs.
6. Programming is designed to be outdoors and may be moved indoors based on extreme weather
7. All hospital recommended COVID-19 screening protocols and personal protective equipment will be implemented for staff and clients

### Section A Registration for SPIRAL GARDEN program

#### Things to Know

- Participants must be 6-18 years old on or before December 31, 2023
- Registration is open to all children
- There are limited participant spots for children with higher support needs.
- After all interested participants receive one session, requests for a 2<sup>nd</sup> session will be considered. Please provide 4 choices. We will aim to offer you your first choice but this cannot be guaranteed.
- Participants will be assigned a session based on staffing levels and ability to accommodate participant needs.
- \* One-week sessions may be available pending capacity. Please inquire about the one-week sessions.

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*Please indicate the sessions that your child is able to attend; we will make every attempt to accommodate your first or second choice based on staffing and ability to support clients' needs.*

<b>Register for Spiral Garden:</b>	<b>Summer 2023 Dates:</b>	<b>Preference</b> (Please indicate 1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> and 4 <sup>th</sup> choice)
<input type="checkbox"/> \$660 Spiral Garden <b>Session A</b>	July 10-21	_____
<input type="checkbox"/> \$660 Spiral Garden <b>Session B</b>	July 24-August 4	_____
<input type="checkbox"/> \$595 Spiral Garden <b>Session C</b>	August 8-18 (9 days)	_____
<input type="checkbox"/> \$660 Spiral Garden <b>Session D</b>	August 21-September 1	_____

### Section B Registrant (Child) Information\*

First time applying to Spiral Garden?  YES  NO

First Name:

Last Name:

Age:

Gender & Pronouns:

Birthdate (dd-mm-yyyy):

Healthcard #:

Family Physician Name & Phone #:

Has your child received other Holland Bloorview services?

YES  NO

If yes, where?: \_\_\_\_\_

Does your child receive clinical care outside of Holland

Bloorview?  YES  NO

If yes, where? \_\_\_\_\_

Do you give consent for us to discuss how to maximize your child's participation in Spiral Garden with other Holland Bloorview teams?  YES  NO

Do you give consent for us to contact my child's external healthcare team in order to maximize their participation in Spiral Garden?  YES  NO

Name of Clinician: \_\_\_\_\_

Contact Information: \_\_\_\_\_

Name of clinician: \_\_\_\_\_

Contact Information: \_\_\_\_\_

I understand that information disclosed about my child's healthcare will only be used to understand how Spiral Garden staff can best support my child's needs and maximize their participation during the program. I understand that Holland Bloorview collects, uses and shares this information under the authority of the Public Hospitals Act and Personal Health Information Protection Act (PHIPA).

### Section C Family Contact Information

(1) Parent/Guardian Name:

Mailing address:

Email address:

City:

Province:

Postal Code:

Home Phone:

Work Phone:

Cell Phone:

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<b>(2) Parent/Guardian Name:</b>		
Mailing address:		Email address:
City:	Province:	Postal Code:
Home Phone:	Work Phone:	Cell Phone:
<b>(3) Emergency Contact Name:</b>		
Home phone:	Work phone:	Cell phone:

<b>Section D Allergies and Medication</b>	
Does your child have any allergies?	<input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please specify:
If yes, what is the treatment for an allergic reaction?:	
Will your child have an EpiPen with them in the program?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Will your child be taking medication while in the program?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, please describe the medication.	

<b>Section E Support Needs Information</b>		
<p>Please provide the following details to assist us in determining the level of support required for your child. Children who require staff support to participate successfully in this outdoor program will be provided a Holland Bloorview staff or volunteer, based on availability.</p>		
<b>(1) What types of activities does your child like doing?</b>	<b>What are some of their favourite things to do?</b>	<b>What are some of their routines for comfort:</b> <i>Favourite book, toy, song, active/quiet, tactile/sensory, other</i>
<b>(2) Diagnosis or Special Need(s):</b>		

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**(3) Mobility:** Is your child at risk of falling? (eg. Fallen in the last three months as a result of diagnosis)  
 YES  NO

My child uses:  support when walking  a walker    wheelchair:  manual  electric/power  
 hand-over-hand assistance     splints/orthotics – if YES, when?

My child needs an assistive device for lifts and transfers (eg. Hoyer lift, sling, etc.)  YES  NO

**(4) Toileting:**

Does your child need assistance with toileting?  YES  NO

If yes, please specify toileting routine details below (send slings and personal care items with your child)

Child's weight: \_\_\_\_\_ lb / \_\_\_\_\_ kg

<b>Bowel</b>	<b>Bladder</b>	<b>Requires</b>	<b>Uses</b>
<input type="checkbox"/> Full control <input type="checkbox"/> Occasionally incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Colostomy Bag <input type="checkbox"/> Toilet Training	<input type="checkbox"/> Full control <input type="checkbox"/> Occasionally Incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter routine Type/size: _____ Times: _____ <input type="checkbox"/> Drainage Condom <hr/>	<input type="checkbox"/> Diapers/briefs: Size: _____ Type: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Toilet <input type="checkbox"/> Commode Chair <input type="checkbox"/> Change Table

**(5) Eating:**

Does your child need assistance eating?  YES  NO

If yes, please specify assistance needed below: *(Please send all food/equipment you child requires)*

<input type="checkbox"/> Regular texture <input type="checkbox"/> Special: <hr/>	<input type="checkbox"/> G-Tube <input type="checkbox"/> NG Tube <input type="checkbox"/> GJ Tube Tube size: _____ Type and amount of feeding/formula: _____	<input type="checkbox"/> Difficulty Chewing <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Bottle fed <input type="checkbox"/> Total Parenteral Nutrition (TPN)	Other <i>(cultural/religious diet implications):</i>  
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**(6) Communication:**

Does your child need assistance communicating?  YES  NO

My child communicates:  verbally  with gestures  with sign language:

with pictures  with an assistive device/book:

**(7) Behaviour/Coping Patterns:** When in program, could your child?

<input type="checkbox"/> YES <input type="checkbox"/> NO Get overwhelmed by loud/sudden noises?	Frequency: <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rarely
<input type="checkbox"/> YES <input type="checkbox"/> NO Get overwhelmed by large groups of people?	<input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rarely
<input type="checkbox"/> YES <input type="checkbox"/> NO Try to run away or leave the group/activity?	<input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rarely
<input type="checkbox"/> YES <input type="checkbox"/> NO Harm themselves?	<input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rarely
<input type="checkbox"/> YES <input type="checkbox"/> NO Harm others?	<input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rarely
<input type="checkbox"/> YES <input type="checkbox"/> NO Participate without support?	<input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rarely
<input type="checkbox"/> YES <input type="checkbox"/> NO Put non-food items in mouth that could be a choking hazard? (e.g., clay, paint, small objects, fabric etc.)	<input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rarely

Please describe your child's behavior where they might need staff support (e.g. trying to leave activity/area, harming themselves/others, etc.):

Please list any triggers for your child behaviours:

Please list any strategies that work to redirect your child and support them to regain self-regulation (re: specific sayings/language, certain activities, etc):

Have there been any recent and major changes in your child's life? If YES, please describe:

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<b>Section F Seizures, Pain Management and Special Consideration</b>	
<b>(1) Seizures:</b> Does your child experience seizures? <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of last seizure (dd-mm-yyyy):
What does a seizure look like (type, frequency, triggers, etc)?	
Will your child have seizure medication with them in the program? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Does your child have a Vagal Nerve Stimulator (VNS)? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>(2) Pain:</b> How will your child let us know they are experiencing pain?	
How can we help to alleviate this pain?	
<b>(3) Other Considerations:</b> My child uses/requires:	
<input type="checkbox"/> helmet <input type="checkbox"/> tip suctioning <input type="checkbox"/> deep suctioning <input type="checkbox"/> physical restraints (eg. Elbow splints, mitts) <input type="checkbox"/> other (please describe:	
<b>Does your child need an increased level of support to be safe and successful in this outdoor program?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>If yes, do they need increased support</b> <input type="checkbox"/> All the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Rarely	
My child needs increased level of support for: <input type="checkbox"/> toileting <input type="checkbox"/> eating <input type="checkbox"/> maintaining self-regulation <input type="checkbox"/> mobility Please describe:	If a staff or volunteer supported spot cannot be provided, are you able to provide your own staff for the program? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE

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<b>Section G Payment Information</b>		
<p><b>Select a payment method in order for your registration form to be processed.</b> Payment may be made by cash, cheque, credit card or funding/financial assistance. Please tell us below if you would like to pay in smaller payments. TOTAL AMOUNT: _____</p>		
<p>I would like to pay by:</p> <ol style="list-style-type: none"> <li><input type="checkbox"/> Funding – I have applied for funding from Holland Bloorview</li> <li><input type="checkbox"/> Funding – I have applied for other funding</li> <li><input type="checkbox"/> Cheque # _____ Cheque date _____</li> <li><input type="checkbox"/> Cash \$ amount _____</li> <li><input type="checkbox"/> Credit Card: <input type="checkbox"/> Mastercard <input type="checkbox"/> Visa <input type="checkbox"/> AMEX</li> </ol>		
Credit Card #	Expiry Date	Security Code:
Name on the card		
Signature		
<p><input type="checkbox"/> I consent for Holland Bloorview to file payment information for this season and understand that payment will only be stored for Spiral Garden 2023. I understand I will need to provide payment information for each seasonal application and that once payment has been processed, my payment information will be taken off file and destroyed.</p> <p><input type="checkbox"/> I do not consent for payment information to be provided with this application or kept on file and would like to be contacted via phone at the time of payment to provide credit card details.</p>		

<b>Section H What happens next?</b>	
<p>Submit your form using the information on the right. You will receive a confirmation and receipt via email, mail, or a phone call if more information or if Participant Screening Visit is required.</p> <p><b>Registration closes:</b> April 1<sup>st</sup>, 2023  <b>Confirmations will be sent:</b> no later than May 1<sup>st</sup>, 2023  <b>Lottery for clients with disabilities that have applied after April 1<sup>st</sup> will occur:</b> May 15<sup>th</sup>, 2023</p> <p>Payments will be processed with your registration confirmation</p> <p>If you are applying for funding, please apply for funding as soon as possible. Payment may be required prior to approval, in which case you funding would act as reimbursement</p>	<p><b>Please send your form to:</b></p> <p>Holland Bloorview Kids Rehabilitation Hospital c/o Music and Arts</p> <p>150 Kilgour Rd. Toronto, ON M4G 1R8</p> <p>Fax: (416) 753-6013</p>

<b>Section I How did you find out about us?</b>	
<input type="checkbox"/> My child has been in a Music and Arts program before	<p><b>Contact Music and Arts:</b></p> <p>Monday-Friday, 8:30am – 4:00pm</p> <p>(416) 425-6220 ext. 3317</p> <p>musicandart@hollandbloorview.ca</p>
<input type="checkbox"/> From my child's healthcare provider	
<input type="checkbox"/> From another parent/family <input type="checkbox"/> From my child's school	
<input type="checkbox"/> Online (Holland Bloorview website, Facebook, etc.)	
<input type="checkbox"/> Other:	