Wheelchair Basketball Drop In 2025-26

General Applicant Information and Diagnosis

Last Name:	**Initial:**	**First Name:**

Gender: ☐Male ☐Female	**Date of Birth *(mm/dd/yy):***	**Health Card Number:**	**Version Code:**

Email address:

Telephone contact: Home:
Cell:

Emergency contact:
Name:
Relationship to the child:
Telephone: ( ) ☐Home ☐Cell ☐Work
Telephone: ( ) ☐Home ☐Cell ☐Work

Primary Diagnosis:_____ **Secondary Diagnosis:**_____
Additional Comments:_____
_____
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Section C – Health Information

Do you experience seizures? ☐Yes ☐No **Date of late seizure:** DD/MM/YYYY:	**If yes, please describe:** **Type of seizure:** **Frequency:** **Intervention/how they are managed:**
Do you have any allergies? ☐Yes ☐No **Please specify - food, environmental, substance, etc.**	**Are there any special considerations staff should be aware of?** **(i.e. do you have any practices specific to cultural beliefs; do you experience pain/discomfort; are there any foods you have difficulty eating; tendency to wander, anxiety in crowds, environments; etc.?)**

Risk of falls

Is there a history of illness-related falls? ☐Yes ☐No	**If yes, please explain:**
Are there any strategies in place to prevent the occurrence of falls? ☐Yes ☐No	**If yes, please explain:**

Section E – Medication

Do you take any medication? ☐Yes ☐No **(Please consider routine medication, emergency medication and as needed medication such as Tylenol or Gravol)**	**Do you take your medication during the session?** ☐Yes ☐No **If yes, please indicate the type of assistance required:** _____

Section H – Activity Participation

Do you have any medical concerns that would make participation in physical activity risky? ☐Yes ☐No
If yes, please explain:

How can staff/volunteers best support with transfers to our Sports Wheelchairs (if applicable)?

What are your goals/best hopes for participating in wheelchair basketball?

Section M: Verification and Signature

I verify that the information that has been given in this application is complete and accurate to the best of my knowledge.

Applicant Signature:	Date *(mm/dd/yy)*:
Parent/Guardian Signature:	Date *(mm/dd/yy)*:

Please return this form to:
Holland Bloorview Kids Rehabilitation Hospital | Lindsey White
Participation & Inclusion, Therapeutic Recreation & Life Skills |
150 Kilgour Road, ON M4G 1R8 | Tel: 416.425.6220 ext.3541|