Wheelchair Basketball Drop In 2026-27

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|

The personal information you give us on this form helps us provide you with services at Holland Bloorview. We collect, use and share this information under the authority of the Public Hospitals Act. If you have questions, please contact the privacy office at 416-425-6220 ext. 3467 or privacy@hollandbloorview.ca.