56A Mill Street E Unit #494
Acton, ON L7J 1H3

P 1-800-804-6130
F-1-800-804-6130
hello@springcare.ca
www.springcare.ca

Participant Information Sheet

Participant Name:_____

Participant Address:_____

Participant Phone number: _____

Email:_____

Date of Birth: _____ Health Card Number: _____

Diagnosis:_____

Allergies:_____

Communication (example: Sign Language, Bliss Board): _____

Safety Concerns:_____

Springcare can email me: ☐Yes ☐No Springcare can text me: ☐Yes ☐No

Please indicate which program (s) you are interested in attending:

Respite Support: ☐ Reverse Respite: ☐ Adult Day Program: ☐ After School Respite Program: ☐

Please indicate which day(s) you are looking for support:

☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐ Friday ☐Saturday ☐Sunday

If requiring respite services, please indicate preferred time of day below:

_____

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Primary Contact for Participant (if applicable)

Primary Contact: _____

Relationship to Participant: _____

Address:_____

Phone Number: _____

Email: _____

Springcare can email me: ☐Yes ☐No Springcare can text me: ☐Yes ☐No

Emergency Contacts

Emergency Contact 1 (can be primary contact):_____

Relationship to Participant: _____

Phone Number: _____

Emergency Contact 2:_____

Relationship to Participant: _____

Phone Number: _____

Emergency Contact 3:_____

Relationship to Participant: _____

Phone Number: _____

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Participant Needs Assessment

The Participant can tell people their name, and their contact information.	☐Yes	☐No
Can the Participant eat independently. If not, please explain the limitations below:	☐Yes	☐No
Does the Participant require assistance with toileting? If yes, explain what assistance is needed:	☐Yes	☐No
Does the Participant have a behaviour support plan? If yes, please provide a copy.	☐Yes	☐No
Does the Participant require any medication while at program? If yes, explain what support is required:	☐Yes	☐No

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Can the participant respond appropriately to an emergency? Example: fire alarm sounds they get up and ready to leave the building.	☐Yes	☐No
Does the participant elope?	☐Yes	☐No

Participant Preferences:

Please check off any of the boxes below if the participant would enjoy these activities:

☐ Bingo	☐ Walks/ Hikes	☐ Movie Outing	☐ Baking
☐ Board Games	☐ Puzzles	☐ Bowling	☐ Library Outing
☐ Yoga	☐ Science Activities	☐ Farm Outing	☐ Pet Therapy
☐ Dance	☐ Reading	☐ Arts and crafts	☐ Creative Writing

Please list any other activities they enjoy below:

_____

_____

_____

_____

_____

_____

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Does the participant have any fears we should know about? (example: Dogs, insects and etc.)

_____

_____

_____

_____

_____

_____

What is their:

Favourite food? _____

Favourite movie? _____

Favourite store? _____

Favourite Animal? _____

Favourite thing to do? _____

What is a great conversation starter/ rapport building topic for the participant?

_____

_____

_____

_____

Springcare SOLUTIONS

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Please list any other important information below: