AZRIELI LEISURE ACTIVITIES FOR ADULTS
Registration Form

PARTICIPANT PROFILE

IMPORTANT :

Please attach a RECENT photo here

Required for ID

Participant name:
_____

Date of birth: _____ / _____ / _____ Age: _____

Height: _____ Weight: _____ Eye color: _____

Hair color: _____

Language(s) used: _____Verbal ☐ Non-verbal ☐

Receiving services from: Miriam H&S ☐ CROM ☐ Other (please specify) ☐
_____

Name of educator/social worker: _____

Type of residential settings: Private home or apt ☐ R.C. ☐ R.T.F ☐

Permanent address: _____

Primary phone number (for animators use): _____ relationship to participant:
_____

Secondary phone: _____ relationship to participant: _____

Email: _____

Emergency contact person: _____ Phone number: _____

DIAGNOSIS: _____

IMPORTANT: Tell us about the participant/yourself: likes and dislikes, any pertinent information our animators should know regarding personality, behavior, distinguishing physical, emotional, mental, and intellectual traits, etc. Please, attach behaviour plan, if applicable.

General:_____
_____
_____
_____

Behaviours:_____
_____
_____

_____

_____

Strategies:_____

_____

_____

_____

Interests:_____

_____

_____

TRANSPORTATION ABILITIES

Able to use public transit independently? YES ☐ NO ☐

Familiar bus routes/frequented areas: _____

Street safety skills? YES ☐ NO☐ Comment: _____

FILE NUMBER for adapted transport: (if applicable) _____

MEDICAL INFORMATION:

Medicare number: _____Expiry Date: _____

Health problems (specify):

Cardiac Problems ☐ Diabetes ☐ Asthma ☐ Coagulation Problems ☐

Epilepsy ☐

- Triggers : _____
- Procedures : _____

Other ☐ _____

Allergies ☐ _____

Epi-Pen : YES ☐ NO ☐

MEDICATIONS: During or outside of program hours: PRN, MEDICATION SOLD OVER THE COUNTER, VITAMINS, ETC. We must have written notification of any medication changes when they occur:

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Medication: _____Dose: _____ Time given: _____

Medication: _____ Dose: _____ Time given: _____

Medication: _____ Dose: _____ Time given: _____

Pharmacy: _____ Tel No: _____

Name of treating physician: _____ Tel No: _____

CONSENT TO RELEASE OF PHOTOS

I authorize Miriam/Miriam Foundation to use videos or photographs of the participant taken during the activities for promotional purposes (donor report, social networks).

YES ☐ NO ☐

Signature : _____ Date : _____

Form completed by : _____ Tel No : _____

Relationship to participant: _____

LIST OF DESIRED ACTIVITIES

ACTIVITY	DAY OF THE WEEK	HOURS