# EAF Icon_blue.JPGhamilton & district extend-a-family

### Natural Family Application

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| client (child/Teen) Information | | | | | | | | | | | | | | | | | | | | | | |
| Surname | |  | | | First Name | |  | | | | | | Sex | | M  F | D.O.B. | | \_\_\_\_\_\_\_\_\_YR \_\_\_\_\_MTH\_\_\_\_\_DAY | | | | |
| Street Address | | |  | | | | | | | | | | Apartment/  Unit # | | |  | | | | | | |
| City |  | | | | Prov. | |  | | | | | | Postal Code | |  | | | | | | | |
| Resides With | | | Mother  Father  Guardian  Other  Please explain: | | | | | | | | | | | | | | | | | | | |
| Allergies | | | | | | YES | NO | | What is the child allergic to? | | | | | |  | | | | | | | |
| Does child use an EpiPen© or puffer? | | | | | | YES | NO | | If yes, under what circumstances? | | | | | |  | | | | | | | |
| Prescribed Medications: | | | | | | | | | | | | | | | | | | | | | | |
| Dietary Restrictions: | | | | | | | | | | | Toileting Needs: | | | | | | | | | | | |
| Mobility Restrictions: | | | | | | | | | | | | | | | | | | | | | | |
| Conditions: Cerebral Palsy  Spina Bifida  Down Syndrome  Muscular Dystrophy  Autism  Asperger’s Syndrome | | | | | | | | | | | | | | | | | | | | | | |
| ADD  ADHD  OCD  PDD  Tourette’s Syndrome  Seizures  FASD  Hearing/Speech/Vision  Diabetes | | | | | | | | | | | | | | | | | | | | | | |
| Heart Problems  Asthma  Developmental Disability  Behavioural Issues  Emotional Issues  Anxiety  Other | | | | | | | | | | | | | | | | | | | | | | |
| Provide Details: | | | | | | | | | | | | | | | | | | | | | | |
| Does the child have a history of violent behaviours? YES  NO  If yes, give details: | | | | | | | | | | | | | | | | | | | | | | |
| Is the child a flight risk? YES  NO  If yes, give details: | | | | | | | | | | | | | | | | | | | | | | |
| Does the child enjoy social outings: YES  NO  If yes, indicate types of outings: | | | | | | | | | | | | | | | | | | | | | | |
| Primary/secondary Contact information (parent/guardian) | | | | | | | | | | | | | | | | | | | | | | |
| Primary Contact | | |  | | | | | | | Relationship to Child | | | |  | | | | | | | | |
| Street Address | | |  | | | | | | | City | | |  | | | | | | Postal Code | |  | |
| Home Phone Number | | |  | | | | | | | Cell/Work Phone Number | | |  | | | | | | | | | |
| Email Address | | |  | | | | | | | | | | | | | | | | | | | |
| Secondary Contact | | |  | | | | | | | Relationship to Child | | | |  | | | | | | | | |
| Street Address | | |  | | | | | | | City | | |  | | | | | | Postal Code | |  | |
| Home Phone  Number | | |  | | | | | | | Cell/Work  Phone | | |  | | | | | | | | | |
| Email Address | | |  | | | | | | | | | | | | | | | | | | | |
| Household information | | | | | | | | | | | | | | | | | | | | | | |
| Who else lives in the household? | | | | | | | | | | | | | | | | | | | | | | |
| Name | |  | | | | | | Relationship to Child | | | | | | |  | | | | | | Age |  |
| Name | |  | | | | | | Relationship to Child | | | | | | |  | | | | | | Age |  |
| Name | |  | | | | | | Relationship to Child | | | | | | |  | | | | | | Age |  |
| Name | |  | | | | | | Relationship to Child | | | | | | |  | | | | | | Age |  |
| Name | |  | | | | | | Relationship to Child | | | | | | |  | | | | | | Age |  |
| Emergency Information | | | | | | | | | | | | | | | | | | | | | | |
| Child’s Surname | |  | | | First Name | |  | | | | | | Sex | | M  F | D.O.B. | \_\_\_\_\_\_YR \_\_\_\_MTH\_\_\_\_DAY | | | | | |
| Street Address | | |  | | | | | | | | | | Apartment/  Unit # | | |  | | | | | | |
| City |  | | | | Prov. | |  | | | | | | Postal Code | |  | | | | | | | |
| OHIP Number | | |  | | | | Home Phone Number | | | | | |  | | | Parent/Guardian Cell Number | | | |  | | |
| Allergies | | | | | | YES | NO | | What is the child allergic to? | | | | | |  | | | | | | | |
| Does the child use an EpiPen© or Puffer | | | | | | YES | NO | | If yes, under what circumstances? | | | | | |  | | | | | | | |
| Prescribed Medications: | | | | | | | | | | | | | | | | | | | | | | |
| Dietary Restrictions: | | | | | | | | | | | | Toileting Needs: | | | | | | | | | | |
| Mobility Restrictions: | | | | | | | | | | | | | | | | | | | | | | |
| Conditions: Cerebral Palsy  Spina Bifida  Down Syndrome  Muscular Dystrophy  Autism  Asperger’s Syndrome | | | | | | | | | | | | | | | | | | | | | | |
| ADD  ADHD  OCD  PDD  Tourette’s Syndrome  Seizures  FASD  Hearing/Speech/Vision  Diabetes | | | | | | | | | | | | | | | | | | | | | | |
| Heart Problems  Asthma  Developmental Disability  Behavioural Issues  Emotional Issues  Anxiety  Other | | | | | | | | | | | | | | | | | | | | | | |
| Provide Details: | | | | | | | | | | | | | | | | | | | | | | |
| Does the child have a history of violent behaviours? YES  NO  If yes, give details: | | | | | | | | | | | | | | | | | | | | | | |
| Is the child a flight risk? YES  NO  If yes, give details: | | | | | | | | | | | | | | | | | | | | | | |
| Does the child enjoy social outings: YES  NO  If yes, give details of type of outings: | | | | | | | | | | | | | | | | | | | | | | |
| emergency Contact information -to be contacted if primary contacts cannot be reached | | | | | | | | | | | | | | | | | | | | | | |
| Name | | |  | | | | | | | Relationship to Child | | | |  | | | | | | | | |
| Home Phone | | |  | | | | | | | Cell/  Work Phone Number | | |  | | | | | | | | | |
| Name | | |  | | | | | | | Relationship to Child | | | |  | | | | | | | | |
| Home Phone | | |  | | | | | | | Cell/  Work Phone | | |  | | | | | | | | | |
| Family Doctor | | |  | | | | | | | Dr. Tel.# | | |  | | | | | | | | | |
| Waiver | | | | | | | | | | | | | | | | | | | | | | |
| I am the parent or guardian of the above-named client and give consent to Hamilton & District Extend-A-Family to share information about this individual with Contact Hamilton and any other agency that has a relevant interest in their well-being provided staff members exercise discretion, document such correspondence, and honour confidential and personal details whenever possible: \_\_\_\_\_ Yes \_\_\_\_\_ No  I acknowledge that the above-named client will be engaging in activities organized and/or arranged for by Hamilton & District Extend-A-Family and that these may be outside the scope of his or her daily routine. I acknowledge that participation in such activities may expose the above-named client to the possibility of injury. I grant Hamilton & District Extend-A-Family staff and adult volunteers the authority to obtain emergency medical treatment as necessary to ensure that the above-named client is protected from further harm or injury. I agree to waive and release Hamilton & District Extend-A-Family from all claims for damages that may arise, other than by negligence of Hamilton & District Extend-A-Family, or its employees, volunteers, and agents, as a result of this child’s participation in agency events: \_\_\_\_\_ Yes \_\_\_\_\_ No  I give permission for this individual to travel with agency staff and/or adult volunteers to scheduled events: \_\_\_\_\_ Yes \_\_\_\_\_ No  I grant Hamilton & District Extend-A-Family consent to use photographs or video footage taken by agency staff or volunteers to promote our agency via internet, social networking sites, agency newsletters, brochures, and other media: \_\_\_\_\_ Yes \_\_\_\_\_ No | | | | | | | | | | | | | | | | | | | | | | |
| Name of Parent/Guardian | | | |  | | | | | | | | | | | | | | | | | | |
| Signature | | | |  | | | | | | | | | | | | Date |  | | | | | |
| Notes: | | | | | | | | | | | | | | | | | | | | | | |