



HAMILTON & DISTRICT EXTEND-A-FAMILY

Natural Family Application

CLIENT (CHILD/TEEN) INFORMATION

Surname	First Name	Sex	M <input type="checkbox"/>	F <input type="checkbox"/>	D.O.B.	_____YR _____MTH_____DAY
Street Address				Apartment/ Unit #		
City	Prov.	Postal Code				
Resides With Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian <input type="checkbox"/> Other <input type="checkbox"/> Please explain:						
Allergies		YES <input type="checkbox"/>	NO <input type="checkbox"/>	What is the child allergic to?		
Does child use an EpiPen® or puffer?		YES <input type="checkbox"/>	NO <input type="checkbox"/>	If yes, under what circumstances?		
Prescribed Medications:						
Dietary Restrictions:				Toileting Needs:		
Mobility Restrictions:						
Conditions: Cerebral Palsy <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Autism <input type="checkbox"/> Asperger's Syndrome						
ADD <input type="checkbox"/> ADHD <input type="checkbox"/> OCD <input type="checkbox"/> PDD <input type="checkbox"/> Tourette's Syndrome <input type="checkbox"/> Seizures <input type="checkbox"/> FASD <input type="checkbox"/> Hearing/Speech/Vision <input type="checkbox"/> Diabetes						
Heart Problems <input type="checkbox"/> Asthma <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Behavioural Issues <input type="checkbox"/> Emotional Issues <input type="checkbox"/> Anxiety <input type="checkbox"/> Other <input type="checkbox"/>						
Provide Details:						
Does the child have a history of violent behaviours? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, give details:						
Is the child a flight risk? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, give details:						
Does the child enjoy social outings: YES <input type="checkbox"/> NO <input type="checkbox"/> 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	
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

EMERGENCY INFORMATION

Child's Surname	First Name	Sex	M <input type="checkbox"/> F <input type="checkbox"/>	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 <input type="checkbox"/>	NO <input type="checkbox"/>	What is the child allergic to?		
Does the child use an EpiPen® or Puffer	YES <input type="checkbox"/>	NO <input type="checkbox"/>	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	
Name	Relationship to Child	
Home Phone	Cell/ Work	
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: