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## Recreation & Leisure Services Registration Package

× Personal Support Plan

### Participant & Contact Information

Individual's Name:	
Address:	
Phone Number:	
Date of Birth:	
Personal Health Number:	
Family Physician & Tel Number:	

First Contact Name:	
Relationship to Participant:	
Home Phone:	Cell Phone:
Work Phone:	
Email Address:	
Address:	

Second Contact Name:	
Relationship to Participant:	
Home Phone:	Cell Phone:
Work Phone:	
Email Address:	
Address:	

### Emergency Contacts

Name	Relationship	Address	Home Phone	Cell Phone

\*Please attach a current photo!

### Personal Information – “Who am I?”

Place of Birth, Religion, Type of Build, Scars/Identifying features, Handedness

### Medical Needs and History -

Diagnosis/Syndrome:

Medical Needs:

Pain, i.e. does the person experience pain and how does this person indicate pain?:

### Current Behavioural and Mental Health Supports

Describe the individual’s emotional well being (i.e. coping, general temperament, sensitivity to self and others, levels of stability, etc. Include any plans for behavioural, psychiatric, and/or psychological challenges. What does it look like when happy, sad, angry, jealous, and what supports are needed?

### Current Behavioural and Mental Health Supports cont'd...

**\*For the following questions, in addition to responding to current behaviours/supports please let us know if there has been a history of the behaviour (environmental or medical triggers, frequency, patterns and severity).**

Does the individual have a formal diagnosis for Obsessive Compulsive Disorder?

Yes  No

If yes, please provide detailed information, what does the ocd look like and what supports are needed and/or required? Or, if you said no, if the individual shows signs of OCD, please describe what this looks like and what supports are needed and/or required? Additional Comments or information:

Runs or leaves supervision?

Yes  No  Sometimes

If yes, or sometimes, what supports are currently used? Additional Comments or information:

Vocal or Verbal outbursts?

Yes  No  Sometimes

If yes, or sometimes, please describe what typically triggers a verbal outburst, what will we hear, what supports are currently being used. Additional Comments or information:

Aggression?

Yes  No  Sometimes

If yes, or sometimes, please describe what the individual's aggression looks like and what supports are currently used and what typically triggers their aggression. Additional Comments or information:

Sexual Concerns?

Yes  No  Sometimes

If yes, or sometimes, please describe your concerns and what supports are currently being used. Additional Comments or information:

### Phobias/Fears

Include things that cause the person anguish and stress. How can we best support the individual if stressed?

### Communication – “How do I communicate?”

Verbal  Non-verbal  Communicates in other ways

Describe how the individual communicates (verbal, written, sign, gestural, behavioural, language, eye contact, PIC symbols, non verbal, time delay in response, can consent for themselves – people involved who may understand me. How does the individual communicate his or her needs (i.e., fear, pain, anxiety, etc.)? May have a separate plan.

### Cognition – “How do I understand directions?”

Describe the individual’s general level of cognitive functioning (simple, complex, describe level of functioning and best approaches).

### Sensory & Motor Activity

Fine Motor Activity, Gross Motor Activity, Attention Span (Describe the individual's ability to sustain attention), Tics and Habitual Mannerisms (Describe any repetitive movements, habits, etc.), Sensory (Describe the individual's ability to feel hot and cold, depth perception, etc.)

### Eyesight – “What can I see?”

Glasses/Contact Lenses (when are they to be worn):

### Hearing – Hearing Ability

Aids required, earwax buildup and care, deafness (ASL), hear high/low pitches, audiologist assessments. May have a separate plan.

### Nutrition -

Special Diets, Eating Disorders, Allergies, Digestive system – May have a separate plan.

### Allergies -

I.e. milk, nuts, fish, eggs, medications, sunscreen, etc. What happens? What interventions do you use? I.e. Epicene, Benedryl, FLAG/medical alerts in the home on person, have history of past reactions documented. – May have a separate plan.

## Neurological -

Seizures, epilepsy, type, duration, frequency. May have a separate plan.

## Heart & Lung Cardiovascular

Any issues such as blood pressure, congenital heart defects and follow ups, respiratory infections or pneumonia, asthma, medications protocols and approaches. – May have a separate plan.

## Physical Support and Care Information

Toileting Care?

Yes  No

If yes, please explain in detail what care and support is required.

Mobility Issues?

Yes  No

If yes, please explain in detail what support is required.

Wheelchair?

Yes  No

If yes, what support is required?

Mealtime/Eating

Yes  No

Are there concerns around food, i.e. do we need to limit food, encourage eating and/or drinking, encourage nutritious choices, specific dietary needs/concerns, safety issues such as eating too quickly or choking.

## Daily Living Skills – Community:

Personal Safety Awareness (What do we need to know to keep your child safe):

Traffic Awareness such as walking in parking lots, crossing streets, walking down streets (What do we need to know to keep your child safe):

Money Skills such as giving and receiving money, counting bills and coins (How much assistance is required):

Reading level and ability:

Kitchen safety:

Water safety – swimming ability?:

Telephone, i.e. knowing one's phone number, dialing, accessing phone numbers, carrying a personal cell phone (do we need to limit calls made):

Community Mobility, i.e. how does individual get around the community such as HandyDART, parents/caregivers, transit (assisted), transit (unassisted):

Personal Identification, i.e. does the individual carry his/her own i.d.:

Transportation in Vehicles, i.e. where does the individual like to sit in the vehicle, car sickness, does the individual like the windows open/closed, radio on, will they remain in the vehicle, support getting in and out of a vehicle:

What do you like to do in your spare time...

At home:

In the community:

What is important to you? What/who do you need in your life?

How would others describe you?

Who do I perceive my friends are? What support is needed to maintain/enhance friendships?

How would you describe the people you have in your life? What types of personalities do you like to have around you?

Is there anything else you would like us to know about you?

