Health form
Youth Sector

Date: ______/______/______
Day Month Year

(Please write in capital letters)

Participant's information

Family name:______________________________ First name:______________________________

Address: ____ appt no.__________

City:______________________________ Postal code:______________________________

Home phone number :(__________)______________ Adapted transport file #:__________________

Sex: M☐ F☐ Age:________ Date of birth (dd/mm/yyyy): ______/______/______

Parental or legal guardian information

Father's family name:______________________________ Father's first name: ______________________

Home phone: (__________)__________________ Cell phone: (__________) ______________

Office phone: (__________)__________________ Other: (__________) ______________

Mother's family name:______________________________ Mother's first name:______________________

Home phone: (__________)__________________ Cell phone: (_____) ______________

Office phone: (__________)__________________ Other: (_____) ______________

In case of an emergency

Family name:____________________ Name:____________________ Relation: ______________

Home phone: (__________)__________________ Cell phone: (_____) ______________

Office phone: (__________)__________________ Other: (_____) ______________

Medical information

Medicare no.:____ Expiry date:______________________

Name disability:____

Limbs affected:____

Other disabilities:____

Medication:

Does the participant take medication? Yes☐ No☐ If yes, please specify

a) What type of medication?____

b) What is the medication for?____

c) Are there any side effects?____

d) Does the participant have to take this medication during the Viomax program? Yes☐ No☐

Please specify the time and the amount this medication most be taken?______________________

Does the participant wear:

A body brace	Yes	☐	No	☐		
Leg splints/AFOs	Yes	☐	No	☐		
If yes, please specify	right	☐	left	☐	both	☐
Arm splints	Yes	☐	No	☐		
If yes, please specify	right	☐	left	☐	both	☐
Glasses	Yes	☐	No	☐		
Hearing Aid	Yes	☐	No	☐		
If yes, please specify	right	☐	left	☐	both	☐
Does the participant need assistance to use it?	Yes	☐	No	☐		

Allergies

Does the participant have allergies (medication, food, animal…)? Yes☐ No☐

If yes, to what?______________________________

Describe the type of reaction:______________________________

Treatment and medication necessary:______________________________

Is the use of an Epipen required? Yes☐ No☐

Medical history:

Is the participant subject to the following problems? *(Please check the appropriate box)*

Cardiovascular	☐	Muscular	☐	Nervous system	☐	Dizziness	☐
Pulmonary	☐	Articulator	☐	Hepatitis B	☐	Diabetes	☐
High blood pressure	☐	Incontinence	☐	Bone	☐	Visual	☐
Infections	☐	Asthma	☐	Fainting	☐	Hearing	☐

Has the participant ever had epileptic seizures? Yes☐ No☐

If yes, when did the last one occur?________________ How often do they occur?________________________

Describe the seizure:______________________________

Does the participant have a shunt? Yes☐ No☐

If yes, describe any specific care or concerns related to the shunt:______________________________

____

Describe any specific consideration related to your child's medical needs:______________________________

____

____

In general the child has: (please check the appropriate box)

No restrictions with physical activities

Ordinary physical activities are not restricted, but vigorous efforts must be avoided.

Communication:

- Spoken languages — French ☐ English ☐ others:________________________
- Language used to communicate — Spoken ☐ Sign ☐ non verbal ☐
- A communication system — Yes ☐ No ☐ If yes, which one :_______________
- The child makes him/herself understood — Easily ☐ With difficulty ☐
- The child understands: Simple instructions — Easily ☐ With difficulty ☐
  Complex instructions — Easily ☐ With difficulty ☐

The participant needs help to:

Eat	Yes ☐	No☐
Drink	Yes ☐	No☐
Get dressed	Yes ☐	No☐
For toileting	Yes ☐	No☐
For mobility	Yes ☐	No☐

The participant wears diapers	Yes ☐	No ☐
Does the participant catheterize?	Yes ☐	No ☐

If yes please fill the document in annex.

Most of the time, how does the participant move:

Walks alone	Yes ☐	No☐
Alone in a wheel chair	Yes ☐	No☐
With help, in a wheel chair	Yes ☐	No☐
With Canadian crutches	Yes ☐	No☐
With crutches	Yes ☐	No☐
With a walker	Yes ☐	No☐

The participant can transfer: Alone ☐ With help ☐

Does the participant need supervision to transfer? Yes ☐ No ☐

Specify method:

2 person lift	☐
Pivot transfer (stands with support)	☐
Mechanical lift (must be sent from home)	☐

Behaviour

The participant experiences fatigue: Rarely ☐ Often ☐ Always☐

The participant suffers from attention disorder: Rarely ☐ Often ☐ Always☐

Are there any specific methods or "tricks" used to keep the child's attention?________________________

____

His/Her relation with adults, peers and strangers:

Adults: Good ☐ average ☐ poor ☐

Peers: Good ☐ average ☐ poor ☐

Strangers: Good ☐ average ☐ poor ☐

Does the participant have behaviour or aggression problems? Yes ☐ No ☐

If yes, please specify: ____

Does the participant have reactions when he/she feels anxious or annoyed? Yes ☐ No ☐

If yes please specify: ____

Does the participant have worries or fears?____

Pool

Can the participant swim alone? Yes ☐ No ☐

With a flotation device (floater, noodle, belt, etc), please specify: ________________________

What are the child's reactions to water and the swimming pool? ________________________

____

Others

Others specific behaviours not previously mentioned?____

____

____

Comments____

____

____

I authorise VIOMAX to use pictures of my child taken during the activities of the youth sector. Yes ☐ No ☐

Signature:____ Date:________________________

ANNEX
Information on Urinary Probe and Catheter
Parental Authorization

(Please write with capital letters)

Information on Urinary probe

Does your child have a urinary probe? Yes ☐ No☐

Is your child autonomous with it? Autonomous ☐ Need help ☐ Need supervision ☐

Does the catheter need to be done during the hours of activity at Viomax? Yes ☐ No ☐

If yes specify at what time(s):____________________

If the person in charge of doing your child's catheter is absent can the child still pass the day at Viomax?
Yes ☐ No ☐

Parental Authorization

If your child needs help or supervision do you authorize a Viomax employee (if possible the responsible of the team) to be present and do or assist your child with the catheter?
Yes ☐ No☐

Commitment

If your child needs help or supervision and you accept that an employee of Viomax (if possible the team leader) does and/or supervises the catheter of your child, you need to show the employee how to do the catheter of your child. You must also tell us of any changes with your child's catheters or urinary probe.

Parent's signature

Father's Signature: ____

Mother's Signature: ____

Date: ____________________________