



Summer In the City Application

APPLICANT INFORMATION		
Surname	Given First Name	Nickname
Home Address	City, Province	Postal Code
Home Telephone	Date of Birth (MM/DD/YY)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Session: <input type="checkbox"/> July 19th-23rd <input type="checkbox"/> August 16th-20th <input type="checkbox"/> Either week would be fine		
Skills and Abilities		
I am comfortable with the following activities: <input type="checkbox"/> Soccer <input type="checkbox"/> Riding a Bicycle <input type="checkbox"/> Bowling <input type="checkbox"/> Heights and Canopy tours <input type="checkbox"/> Golf <input type="checkbox"/> Riding a train <input type="checkbox"/> Visiting the Aquarium <input type="checkbox"/> Hiking <input type="checkbox"/> Riding Public Transportation [designed to expose participants to active city life and mobility Swimming and Water activities- can swim on own in deep water <input type="checkbox"/> shallow water <input type="checkbox"/> needs lifejacket <input type="checkbox"/> Additional Skills and Abilities we should know about: _____		
Dietary Specifications		
<input type="checkbox"/> I do not have any dietary restrictions I do have dietary restrictions [please check the boxes that apply]: <input type="checkbox"/> Vegetarian <input type="checkbox"/> Vegan <input type="checkbox"/> Lacto-Ovo <input type="checkbox"/> Lactose Intolerant <input type="checkbox"/> Celiac <input type="checkbox"/> Gluten-free <input type="checkbox"/> Diabetic <input type="checkbox"/> I have a food allergy [please specify]: _____ Additional Restrictions we should know about: _____		
CAN will be providing one on one workers, if you prefer to provide your own, please provide your workers details below: Name: _____ Age: _____ Telephone: _____ Email: _____ Dietary restrictions: <i>(please specify)</i> _____ <input type="checkbox"/> I do not require this type of assistance and will not be bringing anyone with me		
PARENT/GUARDIAN INFORMATION		
Parent 1/Guardian Surname	Parent 1/Guardian First Name	
Home Address (if different from above)	City, Province	Postal Code
Home Telephone	Business Telephone	Email
Cell	Other	

Parent 2/Guardian Surname		Parent 2/Guardian First Name	
Home Address (if different from above)		City, Province	Postal Code
Home/Cell Telephone	Business Telephone	Email	
EMERGENCY MEDICAL INFORMATION			
Name of Applicant's Physician		Telephone	
Physician's Address		City, Province	Postal Code
Medical Services Plan Number (Care Card Number of Applicant)			
Does your child have any allergies to food/drugs/environmental substances/chemicals? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please explain)			
Is your child under any ongoing medication? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please list the medications)			
Does your child have any serious medical conditions we should be aware of, eg. seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please describe)			
Does your child have any physical limitations we should be aware of, eg. CP, needs help on stairs? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please describe)			
<p>Sensory Challenges: We will be participating in a variety of activities, it is important to know if your teen has any particular sensory challenges. Please circle any that apply:</p> <p>Visual * Does seeing certain things create a reaction for the individual?</p> <p>Auditory * Does hearing certain things create a reaction for the individual?</p> <p>Tactile * Does feeling certain things create a reaction for the individual?</p> <p>Smell * Does smelling certain things create a reaction for the individual?</p> <p>Please specify any other sensory challenges: _____</p>			

Communication Skills: Learns best with <input type="checkbox"/> Pictures <input type="checkbox"/> Verbal <input type="checkbox"/> Pictures + Verbal <input type="checkbox"/> Signing <input type="checkbox"/> Words <input type="checkbox"/> Other please specify : _____	Communicates best with <input type="checkbox"/> Pictures <input type="checkbox"/> Verbal <input type="checkbox"/> Pictures + Verbal <input type="checkbox"/> Signing <input type="checkbox"/> Words <input type="checkbox"/> Other please specify: _____
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Does your child have a specific behavior plan? **Yes** **No**
(If yes, please include any necessary information for our staff and volunteers)
What is an effective time out strategy to use?

In the case of an emergency who, other than the parents/guardians, should be called?

Please specify any additional information you may like to relay to volunteers and staff:

I authorize The Canucks Autism Network Society (CAN) to use any pictures or video of my child while engaging in CAN programs for promotional, informational and educational purposes on websites, printed material, and media. Yes No

Signature _____ **Date** _____

Parent 1/Guardian Signature

Print Name	Date
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Parent 2/Guardian Signature

Print Name	Date
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_____ I consent to any photos being distributed by CAN for promotional purposes
 [initials]