

PARTICIPANT PROFILE

Participant name: _____

Date of birth: ____ / ____ / ____ Age: ____

Hight: ____ Weight: ____ Eye color: ____ Hair color: ____

Language(s) used: _____ Verbal Non-verbal

Receiving services from: Miriam H&S CROM Other (please specify)

Name of educator/social worker: _____

Type of residential settings: Private home or apt R.C. R.T.F

Permanent address: _____

Primary phone number (for animators use): _____ Secondary phone: _____

Email: _____

Emergency contact person: _____ Phone number: _____

IMPORTANT:

VEUILLEZ
ANNEXER UNE
PHOTOGRAPHIE
RÉCENTE ICI.

PHOTO REQUISE
À DES FINS
D'IDENTIFICATIO

DIAGNOSIS

IMPORTANT: Tell us about the participant/yourself likes and dislikes, any pertinent information our animators should know regarding personality, behavior, distinguishing physical, emotional, mental, and intellectual traits, etc. Please, attach behaviour, plan if applicable.

TRANSPORTATION ABILITIES

Able to use public transit independently? YES NO

Familiar bus routes/frequented areas: _____

Street safety skills? YES NO Comment: _____

Transport Adapté FILE NUMBER: (if applicable) _____

MEDICAL INFORMATION:

Medicare numbers : _____ Expiry Date: _____

Health problems (specify) :

Cardiac Problems Diabetes Asthma Coagulation Problems

Epilepsy

○ Triggers : _____

○ Procedures : _____

Other _____

Allergies _____

Epi-Pen : YES NO

MEDICATIONS: During or outside of program hours: PRN, MEDICATION SOLD OVER THE COUNTER, VITAMINS, ETC. Medication taken during program hours must be listed separately, below, and sent in a clearly labelled dosette box. We must have written notification of any medication changes when they occur:

Medication: _____ Dose: _____ Time given: _____

Medication: _____ Dose: _____ Time given: _____

Medication: _____ Dose: _____ Time given: _____

Pharmacy: _____ Tel No: _____

Name of treating physician: _____ Tel No: _____

CONSENT TO RELEASE OF PHOTOS

I, the undersigned, authorize the Miriam Intervention/Miriam Foundation to use photographs/digital images of the participant taken during activities for promotional purposes such as letters to Foundation donors : YES NO

Signature : _____ Date : _____
(Please sign and indicate relationship to participant, i.e.,: parent, tutor, guardian, etc.)

Form completed by : _____ Tel No : _____

PAYMENT INFORMATION:

Credit Card: Jasmine Kooner (514-345-1300 x 312) Sarah Lhynn Sevilla (514-345-1300 x 411)

Credit Card Information: _____

Cheque: Cold Centre 5703 rue Ferrier Mont-Royal, QC H4P 1N3

Interac e-Transfer: accounts@miriamfoundation.ca Password: CentreGold

LIST OF ACTIVITIES

ACTIVITY	DATE	HOURS	PRICE

TOTAL : _____