Open Doors

Day Program

REGISTRATION PACKAGE

Thank you for your interest in Open Doors Day Program. In this package you will find:

1. Fees and payment PLEASE KEEP FOR YOUR RECORDS
2. Registration form
3. Medical forms
4. Sample Program

Please don't forget to:

- Fill in with as much details as possible
- Read Our Policies and Procedures
- Return completed package as soon as possible
- Call Kendra Pilon at 519-900-6817 if you have any questions or concerns

Open Doors

FEES AND PAYMENT

Please read through the following carefully.

PAYMENTS:

Fees are due monthly, on the 15th, for the following month. Schedules and calendars for each following month will be sent out on the first business day of the preceding month. Payments can be made by e-transfers or cheques. I understand a $40 fee will be charged for each cheque returned for NSF or other reasons.

***All fees are non transferable or refundable due to staffing needs**.

FULL DAY FEES

Support fees will be determined after a support assessment has been made. We have a three different levels of support. 1:1, 1:3, 1:6.

HALF DAY FEES

Support fees will be determined after a support assessment has been made. *Friends coming to the centre with their own support worker will be given a discounted rate.

HOURLY FEE

Hourly support fees for after school drop in or centre drop in will be $26.00/hr

ALL RATES TO BE DISCUSSED AT ASSESSMENT

TERMINATION NOTICE

Written notice to the director must be given a minimum of two weeks prior to the withdrawal of the participant.

I have read the above and agree to the terms stated.

SIGNATURE _____ DATE _____

Open Doors

Hello Open Door Family!

For booking days you will be sent the following month's schedule and calendar at the beginning of the preceding month. For example, we are asking you to choose your days for the month of June and return such requests to us by **May 15th** with your payment. This will help us with our planning and scheduling of our staff as we continue to grow.

Our Sick Day policy is as follows. When your family member misses a day at the center that is already paid for, we will now be offering the opportunity for you to reschedule that day. This will be done by submitting a request for the rescheduled date to be approved based on the availability of staff and scheduling. **No rescheduled requests are guaranteed.** The number of days you will be allowed to request will be based on the number of days per week you have committed to. For example, if a participant attends 5 days a week, you will be allowed to request up to 10 rescheduled days per calendar year. If they attend 4 days a week you will be allowed up to 8 rescheduled days per calendar year. If they attend 3 days per week, you will be allowed to request up to 6 rescheduled days per calendar year. The full policy will be available in our policy folder, soon to be available for your reference.

Open Doors is a PEANUT, PINEAPPLE AND FISH/SEAFOOD FREE CENTRE DUE TO ALLERGIES. Please do not bring anything with either of these for lunches,

If you have any questions about these adjustments, please do not hesitate to contact me. Thank you for helping to make Open Doors a great place for all of our Friends!

Thanks
Kendra Pilon
Director
Open Doors Adult Day Program

Open Doors

OPEN DOORS REGISTRATION FORM

PARTICIPANT'S NAME _____

DATE OF BIRTH _____

ADDRESS _____

PHONE _____ CELL PHONE_____

HOW MANY DAYS AT THE CENTRE PER WEEK _____

ARRIVAL TIME _____ DEPARTURE TIME_____
*THE PROGRAM IS OPEN MONDAY - FRIDAY FROM 9AM TO 4PM

EMAIL ADDRESS_____(will be used for all communication)

EMERGENCY CONTACT INFORMATION

1) GUARDIAN'S NAME _____

EMAIL ADDRESS(used for all correspondence)

_____

PHONE _____ Ext._____

PLACE OF EMPLOYMENT _____

ADDRESS _____

2) CONTACT'S NAME _____

PHONE _____ Ext._____

Open Doors

DOCTOR'S NAME _____

ADDRESS _____

PHONE NUMBER _____

Please note: It is the guardian's responsibility to let the supervisor/staff know of any changes to the information included on this form.

MEALS AND SNACKS

All meals and snacks are to be provided by the participant. **WE ARE A PEANUT, PINEAPPLE, FISH FREE FACILITY DUE TO ALLERGIES**

ILLNESS

A participant will stay home for a minimum of 24 hours when any of these symptoms that are unusual to them are present:

-Cough	-Sore throat	-Diarrhea
-Nausea or vomiting	-Headache	-Extreme Fatigue
-Fever of greater than 100.4 F		

ABSENTEE POLICY

I will receive no reduction in fees for days that the participant may be absent (due to illness, appointments, etc.).

I have read the above and agree to the terms stated.

GUARDIAN SIGNATURE _____ DATE _____

Open Doors

MEDICAL RELEASE

In the event of a serious occurrence the participant will be taken to the hospital, without consent and will only be treated if life threatening.

It is very important that staff know how to contact you at all times.

I hereby consent to have the participant examined and treated by a physician if an emergency should arise.

PARTICIPANT'S NAME _____

ADDRESS _____

PHONE _____

BIRTH DATE (D/M/YR) _____

HEALTH CARD #_____ (Include the letters at the end)

SIGNATURE _____ DATE _____

*The centre will only administer prescribed medication from a physician. Medication must have the participant's name on it.

*No over the counter medications will be given without a Doctor's prescription on file.

*All medications must be in original packaging from Pharmacy.

Open Doors

MEDICAL FORM

PARTICIPANT NAME _____

PHYSICIAN NAME _____ PHONE _____

DIAGNOSIS _____

_____

_____

ALLERGIES _____

_____

_____

LAST MEDICAL EXAMINATION COMPLETED ON (D/M/Y)_____

TREATMENT PLAN _____

_____

_____

LIST MEDICATION NAME, EXACT DOSE, FREQUENCY, TIME, ROUTE, AND REASON

_____

_____

_____

_____

Open Doors

STANDING ORDERS 1

PARTICIPANT NAME _____

BIRTH DATE (D/M/YR)_____

PHYSICIAN NAME _____

PHONE _____

PHARMACY_____

PHONE _____

ANY WRITTEN INSTRUCTION FOR PARTICIPANT CARE _____

_____

_____

FOR EXAMPLE: CHEST PHYSIO OR RANGE OF MOTION_____

_____

_____

Open Doors

STANDING ORDERS 2

PARTICIPANT NAME _____

BIRTH DATE (D/M/YR)_____

Personal Assistance Service Device(s) this participant will use while at Open Doors
(please check all that apply):

□ **Wheelchair:** This individual uses a wheelchair with a lap belt or restraining belt to assist the individual with a physical disability with positioning or balance.
Additional instructions are as follows:(Insert information on tilt of the chair for certain activities of daily living, uses of a stability belt if applicable).
_____

□ **Mechanical Lift:** This individual weighs more than 70 pounds and requires the use of a mechanical lift. This will allow the individual to be transferred between a bed and a chair or other similar resting places.

□ **Commode:**This individual requires a commode to assist with stabilization/ safety during elimination. While an individual is using a commode he/she will be monitored at all times.
Additional instructions are as follows: (Insert information on the use of the lap belt or safety bar).
_____

□ **Other Equipment:** (e.g. list any other equipment that restricts movement and that the participant may be unable to release themselves from).
Please specify the device and how it will be used for a routine activity of daily living.

Additional Instructions _____

_____

_____

GUARDIAN SIGNATURE _____ DATE _____

Open Doors

LIFE THROUGH MY EYES

To help us provide the best care possible please complete this form as much as you feel comfortable sharing.

NAME _____

I PREFER TO BE CALLED _____

PLACES I HAVE LIVED _____

IMPORTANT RELATIONSHIPS (friends, family, pets) _____

_____

_____

HOBBIES _____

THINGS I LIKE TO WORK ON _____

_____

TO ENJOY MY DAY I NEED TO HAVE (eg. glasses, lotions, pillow, book) _____

_____

_____

IF I BECOME FRIGHTENED OR UPSET, THESE THINGS HELP ME _____

_____

_____

SOME OF MY FAVORITE THINGS
-MOVIES/TV SHOWS _____

-BOOKS/ MAGAZINES _____

-MUSIC_____

-FOOD/DRINKS _____

-ACTIVITIES_____

-OTHER _____

IF YOU WERE TO ASK ME ABOUT MY LIFE THIS IS WHAT I WOULD SAY_____

_____

_____

MY DAILY LIFE COMMUNICATION (language spoken, meanings of special words, supports used, any special instructions) _____

_____

_____

NUTRITION (tools needed, assistance level required, please list and instructions) _____

_____

_____

ELIMINATION (toileting needs, items needed) _____

_____

_____

MOBILITY/POSITIONING _____

_____

_____

_____

_____

BEHAVIORAL CONSIDERATIONS (BSP?) _____

_____

_____

_____

_____

STRENGTHS _____

_____

_____

_____

_____

ANY ADDITIONAL INFORMATION _____

_____

Open Doors

CONSENT FORM

Name of Participant_____

I give Open Doors Day Program permission to take and share photos of_____.

YES **O** NO **O**

I give Open Doors permission to share _____ photos on its social media pages.

YES **O** NO **O**

I give Open Doors permission to use _____ photos for promotional materials in the future.

YES **O** NO **O**

_____ _____

Signature of Parent/Guardian/Caregiver Date