



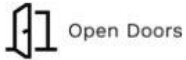
## **REGISTRATION PACKAGE**

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



## **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 \_\_\_\_\_



## 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 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. \_\_\_\_\_

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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

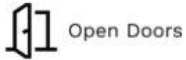
-Fever of greater than 100.4 F

**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 \_\_\_\_\_



## **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.



**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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## **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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_





## **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).

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**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).

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**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 \_\_\_\_\_

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GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



## **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 \_\_\_\_\_

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

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

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ELIMINATION (toileting needs, items needed) \_\_\_\_\_



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MOBILITY/POSITIONING \_\_\_\_\_

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BEHAVIORAL CONSIDERATIONS (BSP?) \_\_\_\_\_

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STRENGTHS \_\_\_\_\_

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ANY ADDITIONAL INFORMATION \_\_\_\_\_

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## **CONSENT FORM**

Name of Participant \_\_\_\_\_

I give Open Doors Day Program permission to take and share photos of \_\_\_\_\_.

YES  NO

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

YES  NO

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

YES  NO

\_\_\_\_\_  
Signature of Parent/Guardian/Caregiver

\_\_\_\_\_  
Date