

In Computer \_\_\_\_\_

VOD \_\_\_\_\_

# ADAPTED RECREATION PROGRAM

Fee \_\_\_\_\_

Paid In Full \_\_\_\_\_

Sp. Oly. Only \_\_\_\_\_

## CHEEKTOWAGA DEPARTMENT OF YOUTH & RECREATIONAL SERVICES

### REGISTRANT INFORMATION

Child's/Ward's Name \_\_\_\_\_ Age \_\_\_\_\_ T-Shirt Size \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Circle: Male or Female

Mail will be addressed to above address unless otherwise stated.

Grade in September \_\_\_\_\_ School Attending/Workplace \_\_\_\_\_

**Parent/Guardians:**

First Contact \_\_\_\_\_ DOB \_\_\_\_\_ Cell/Pager \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Address \_\_\_\_\_

Where Employed \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Second Contact \_\_\_\_\_ DOB \_\_\_\_\_ Cell/Pager \_\_\_\_\_

Relationship to Child \_\_\_\_\_

Address \_\_\_\_\_

Where Employed \_\_\_\_\_ Daytime Phone \_\_\_\_\_

**In the event of an emergency, please notify (other than above):**

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Relationship \_\_\_\_\_ Address \_\_\_\_\_

Family Doctor \_\_\_\_\_ Telephone \_\_\_\_\_

**If you wish to have any additional mailings sent out, please include their name and address:**

Name \_\_\_\_\_

Address \_\_\_\_\_

1) Child's/Ward's Primary Disability \_\_\_\_\_  
Secondary Disability \_\_\_\_\_

2) Type of Classroom \_\_\_\_\_

3) Has this child attended recreation programs before? \_\_\_\_\_ If so, where? \_\_\_\_\_

4) Comment on any difficulties in the area of:  
Sight \_\_\_\_\_

Communication \_\_\_\_\_

Hearing \_\_\_\_\_

Motor Coordination \_\_\_\_\_

5) How does the child express the need to go to the bathroom? \_\_\_\_\_

Is there a toileting program that we need to follow? \_\_\_\_\_ If so, please explain: \_\_\_\_\_

Does child/ward wear liners (diapers)? \_\_\_\_\_

6) Females: Has your child/ward started to menstruate? \_\_\_\_\_ If yes, can she care for herself? \_\_\_\_\_

7) What methods of direction and control do you find most effective? \_\_\_\_\_

8) What do you feel are this child's greatest needs? \_\_\_\_\_

9) Does this child have any special fears? \_\_\_\_\_

10) Favorite pastimes: \_\_\_\_\_

11) Please list any comments that about your child/ward that can help us! \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Information Continued on Back)

