



OVERNIGHT CAMP AND RESPITES

DETAILED HEALTH INFORMATION

PARTICIPANT	
First name	Last
Date of birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Health insurance	Expiry
Does the participant have medical	<input type="checkbox"/> Private <input type="checkbox"/> RAMQ <input type="checkbox"/> Other(s) :
Tetanus vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No Date:
Does the participant have any of the following conditions/illnesses :	
<input type="checkbox"/> Asthma <input type="checkbox"/> Indigestion <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Bulimia <input type="checkbox"/> Constipation <input type="checkbox"/> Heart trouble <input type="checkbox"/> Urinary disorders <input type="checkbox"/> Aids / HIV <input type="checkbox"/> Hepatitis <input type="checkbox"/> Skin problems <input type="checkbox"/> Diabetes (supply diet) <input type="checkbox"/> Epilepsy <input type="checkbox"/> Controlled <input type="checkbox"/> Uncontrolled (<i>Provide pertinent medical reports</i>)	
Does participant suffer from incontinence? <input type="checkbox"/> No <input type="checkbox"/> Yes (mandatory)	
ALLERGIES	<input type="checkbox"/> No <input type="checkbox"/> Yes, please specify:
ALLERGIES food	<input type="checkbox"/> No <input type="checkbox"/> Yes, please specify:
Has an Epipen	<input type="checkbox"/> No <input type="checkbox"/> Yes Other allergies:
Does participant possess a hearing aid?	<input type="checkbox"/> Cochlear implant <input type="checkbox"/> Hearing aid <input type="checkbox"/> Other:
Communicates in: <input type="checkbox"/> LSQ (Québec) <input type="checkbox"/> French <input type="checkbox"/> ASL (American) <input type="checkbox"/> English <input type="checkbox"/> Pictograms <input type="checkbox"/> Non verbal	
Other health conditions, illnesses or handicaps	
Medical history (please include the detailed diagnostic related to the disease or handicap)	
Other pertinent health information	
Does participant have a special risk of dehydration, heat stroke or any infection?	
<input type="checkbox"/> No <input type="checkbox"/> Yes, if so, in what situation:	



À L'ÉTAT *naturel*

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INDEPENDENCE / AUTONOMY			
Dressing:	<input type="checkbox"/> Alone	<input type="checkbox"/> with help, specify:	<input type="checkbox"/> not able
Washing:	<input type="checkbox"/> Alone	<input type="checkbox"/> with help, specify:	<input type="checkbox"/> not able
Going to toilet:	<input type="checkbox"/> Alone	<input type="checkbox"/> with help, specify:	<input type="checkbox"/> reminder
Orientation:	<input type="checkbox"/> Alone	<input type="checkbox"/> with help, specify:	<input type="checkbox"/> not able
Move around:	<input type="checkbox"/> Alone	<input type="checkbox"/> with help, specify:	<input type="checkbox"/> not able
Uses wheelchair or other walking support:	<input type="checkbox"/> Yes, specify:		
EATING HABITS / RESTRICTIONS			
Eats:	<input type="checkbox"/> Alone	<input type="checkbox"/> with help, specify:	<input type="checkbox"/> Not able
Drinks:	<input type="checkbox"/> Alone	<input type="checkbox"/> with help, specify :	<input type="checkbox"/> Not able
Dietary restrictions or intolerance:	<input type="checkbox"/> No <input type="checkbox"/> Yes, specify:		
Food presentation:	<input type="checkbox"/> Normal	<input type="checkbox"/> Chopped	<input type="checkbox"/> Pureed <input type="checkbox"/> Liquid
Type of behavior and level of understanding instructions			
Does the participant have any of these behaviours			
<input type="checkbox"/> Self-aggression	<input type="checkbox"/> Runs away	<input type="checkbox"/> Isolates him/herself	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Aggression towards others	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Autistic gestures	<input type="checkbox"/> Opposition
Causes of disorganization and their control strategies			
Important routine to follow with the participant			
Date		Signature	



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