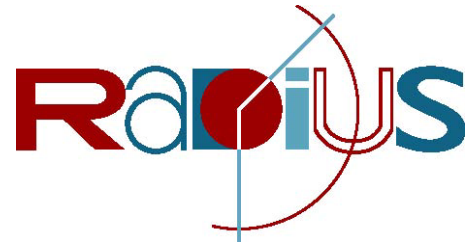


Radius Community Centre
Supports for Working Families of Youth with Disabilities
Youth Companion Program
Application Form



Applicant

Name _____ Age: _____

Birth date _____

Address _____ Phone _____

Postal Code _____ Hospitalization # _____

Parents and/or Guardians

Mother's Name _____ **Address** _____

Home phone _____ Business phone _____

Cell Phone _____ Email _____

Father's Name _____ **Address** _____

Home phone _____ Business phone _____

Cell Phone _____ Email _____

Guardian's Name _____ **Address** _____

Home phone _____ Business phone _____

Cell Phone _____ Email _____

Youth currently lives with: Both Parents Mother Father Guardian

Emergency Contact

Name: _____ Phone _____

Cell Phone _____ Email _____

Educational Information

Saskatoon Public Saskatoon Catholic Other

School _____

Teacher _____

Teacher Associate _____

Grade/Program _____

Other school staff, agencies or counselors involved with the youth and family?

Community Living Division Worker _____

Advocate _____

Health

Does your youth receive any medications? How are they administered? How often?
(Please specify clearly)

Allergies _____

Special Diet _____

Does your youth have:

Seizures No Yes, if yes please answer the following:

Type of seizures _____

Date of last seizure _____

What brings on a seizure _____

Diabetes Vision loss Hearing loss

Does your youth have any other medical conditions that staff need to be aware of? Please describe the condition(s) _____

Communication

How does your youth communicate? (i.e. verbal, sign, gestures, body language, etc.)

Please describe the best way to communicate with your youth _____

Please describe how your youth expresses their thoughts, feelings and needs through their actions _____

How does your youth express themselves when they are frustrated or in a stressful situation? _____

How do you support your youth when they do become upset? _____

Does your youth currently display any inappropriate sexual or verbal or physical aggressive behavior? ___Yes ___No (i.e. self harm, hits or bites others, touches self or others breasts or genitals)

Explain _____

Please specify any situation that appears to trigger aggressive episodes or inappropriate behaviors _____

What strategies are effective in minimizing aggressive or inappropriate behaviors?

How does your youth interact with others in:

One-on-one situations? _____

A group situation? _____

Likes and Interests

What are some of your youth's likes and interests? _____

What are some of your youth's dislikes? _____

Describe your youth's personality, general attitude and motivation

Name friends/family members that your youth may want to visit or do activities with:

Friend's name	Contact information	Details about the relationship
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Recreation and Leisure Activities—what social or recreational activities is your youth involved in? Does he/she require encouragement to become involved?

Weekly Activities Schedule

Weekly home activities schedule:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM							
PM							

Toileting Needs

Does your youth require personal care while toileting? No Yes

If so explain _____

Does your female youth require assistance when menstruating? No Yes

If so explain _____

In order for your youth to feel respected and dignified how might we support that to happen with respect to personal care? (i.e. explain how to properly assist with toileting, changing clothes, etc) _____

Eating

Eats independently Requires some help Needs assistance
Please describe _____

What is your youth's present diet?

What are your youth's favorite foods or food he/she really enjoys?

What are some foods that he/she is allergic to or any dietary restrictions?

Sleep and Rest

Does your youth require rest periods throughout the day? No Yes
Please describe _____

Mobility

Mobile Uses a wheelchair Uses a walker

How much support does he/she need? Please describe _____

Diagnosis

Please share with us information about your youth’s diagnosis that might be helpful for program planning _____

Specific Support Needs

Does your youth require one-on-one support? ___No ___Yes

Does your youth prefer a male companion? ___No ___Yes

Does your youth prefer a female companion? ___No ___Yes

Physical Supports

Are there any aids that are used to assist with your youth’s mobility?

Eyesight: ___good ___short sighted ___long sighted ___no dept perception
___see only shadows ___colour blind ___legally blind ___wears glasses

Comments: _____

Hearing: ___good ___mildly impaired ___impaired ___deaf

Comments: _____

Does your youth wander? ___Yes ___No

Explain: _____

If your youth has a seizure disorder, please describe indicators of pre-seizure and additional comments: _____

Support Requirements

If you are interested in having a companion for your youth please specify the days and dates needed _____

Please specify dates that you are NOT in need of a companion _____

What time of day would you like a companion for your youth?

All day Mornings Afternoons

Please provide specific times _____

Financial Contributions

Family contributions in order to continue this program; have fun summer activities for the youth and hire summer students to supplement other companions when on holidays/sick/etc. are appreciated.

Please mail donation to:
Youth Companion Program
P.O. Box 1812
Saskatoon SK
S7K 3S2

Should you have any questions regarding this application form please contact the Youth Companion Assistant Coordinator, 665-0362, or email yep.radius@sasktel.net

Thank you!