All information collected from the Client intake form assists CPAA in planning and implementing safe and quality programs. Information will only be disclosed to CPAA personnel or necessary personnel of programming partners with expressed permission. Names and photos may be used in promotional documents for CPAA, only when permission has been granted.

Client's Name: _____

Application Date: _____ Client No. _____

Client Profile

Gender:	**Date of Birth (MM/DD/YYYY):**
Marital Status: ☐ **Single** ☐ **Married** ☐ **Cohabitating partner** ☐ **Other**	
Street Address: **City:** **Province:** **Postal Code:**	
Home Phone:	**Cell Phone:**
Email:	**Access Calgary ID # / Edmonton DATS #:**

Current Living Arrangement

☐ **Lives with Family**	☐ **Supportive Roommate**	☐ **Lives Independently**
☐ **Outreach Support**	☐ **Staffed/Group Home**	☐ **Other** _____
Service Provider/Agency:		
Contact Person:	**Phone No.:**	
Email:		

Parent/Guardian/Trustee Information

Last Name:	**First Name:**
Relationship to Client:	
Street Address: **City:** **Province:** **Postal Code:**	
Home Phone:	**Work Phone:**
Cell Phone:	**Email:**

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Type of Guardianship/Trustee: ☐ Self ☐ Custodial ☐ Legal ☐ Total Guardian ☐ Court Guardian

Emergency Contact (Other than Guardian or Home Contact)

Last Name:	First Name:
Relationship to Participant:	
Home Phone:	Work Phone:
Cell Phone:	Email:

Client Disability and Medical Information

Primary Disability:	Secondary Disability:
Please describe Client's disability(ies):	
Alberta Health Care No.:	
Medical Conditions:	
Allergies:	Allergy Kit Needed? :
Doctor's Name:	Doctor's No.:
Specialist Name:	Specialist No.:
Therapist Name:	Therapist No.:

Please note any technical aids Client may need:

Wheelchair/Scooter:	Braces/Crutches/Walker:
Picture Board:	Braille:
Sign Language:	Hearing Aid:
Other Adaptive Equipment (please describe):	

Does Client have a history of seizures? ☐ Yes ☐ No

If yes, please describe the following: pattern, duration, specific considerations, triggers, after care etc….

Please provide any information you feel would be helpful to CPAA staff in providing the best possible experience and care for the Client?

Please indicate (circle) the level of personal assistance the participant requires for the following:

1= Total Independence, 2= Needs Prompting, 3=Needs Some Help, 4=Total Assistance Needed

Eating/Drinking	Toileting	Dressing	Personal Hygiene	Mobility
1 ☐	1 ☐	1 ☐	1 ☐	1 ☐
2 ☐	2 ☐	2 ☐	2 ☐	2 ☐
3 ☐	3 ☐	3 ☐	3 ☐	3 ☐
4 ☐	4 ☐	4 ☐	4 ☐	4 ☐

***Aide must accompany Client to programs if rated higher than a 1 in Toileting.

Does the Client display any of the following behaviours?

Physical Aggression? ☐ **Yes** ☐ **No**	**Verbal Aggression?** ☐ **Yes** ☐ **No**
Running/Wandering? ☐ **Yes** ☐ **No**	**Communication Difficulties?** ☐ **Yes** ☐ **No**
If answered yes to any of the above questions, please provide explanation:	

Additional Background

Likes:
Dislikes:

Service Information

Type of Funding: ☐ Private Native Services Child Welfare Other _____	
☐ **PDD** **Type of Service:**	
Contact Name(if applicable):	**Contact Number:**
Email:	
☐ **AISH** **Type of Service:**	
Contact Name (if applicable):	**Contact Number:**
Email:	
☐ **FSCD** **Type of Service:**	
Contact Name (if applicable):	**Contact Number:**
Email:	

Client's Interest (please check all that is applicable)

- ☐ Adult Support & Meet up Group
- ☐ Employment/Training Support
- ☐ Program Subsidy
- ☐ Vacation Villa
- ☐ Individual Family Support Services
- ☐ Funding Request Package
- ☐ Recreational & therapeutic programs
- ☐ Other _____

Additional Information:

To the best of my knowledge, the above information is accurate and complete. Should anything change, I will be responsible for providing updated information to CPAA staff.

_____ _____

Signature: **Date:**

Permission for Photography/Videography

As the parent/guardian of _____, I herby give CPAA permission for the Client to be photographed/filmed. I understand that photographs and videos may be used for visual presentations (including newsletters, television, website and print media) for community education and fundraising purposes.

_____ _____
Signature of parent/guardian/Client Date

_____ _____
Signature of witness Date

☐ Permission declined

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No person shall participate in any activity or program by the Cerebral Palsy Association in Alberta (CPAA) without reading and agreement of the following release:

Release
In consideration of participation in any program, event, or activity sanctioned by CPAA, the undersigned Client, parent or guardian understands and agrees that the Client does so at his/her own risk, and that CPAA, its employees, volunteers, and other participants will not be liable to anyone in this contract, negligence or otherwise, for any losses, damage or injury to the person or property resulting from, or occurring in connection with CPAA activities.

Indemnification
The undersigned further agrees to completely indemnify CPAA for any expenses or liabilities as a result of any injury or other loss to the Client including cost of ambulance, emergency services and related costs.

Representations as to Medical History of Client
The undersigned does not know of any physical or emotional reason why the participant should not participate in any CPAA program or activity. The undersigned also represents that full disclosure of the Client's medical history has been made known to the Cerebral Palsy Association in Alberta.

Representations as to Authority of Signatory
If the Client is under the age of 18 years (or not their own guardian), the undersigned parent or guardian hereby grants this release on his or her own behalf and on behalf of the participant. The undersigned further represents that he or she has read and understood this Release and, in the case of a parent or guardian, has full authority to execute this release on the Client's behalf.

_____ _____
Signature Printed Name

_____ _____
Signature of Witness Printed Name of Witness

_____
Date

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I _____ hereby give my consent to the Cerebral Palsy Association in Alberta to receive or release information about me from the following Agency (ies) for the purposes of providing services and advocating on my behalf.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Name of CPAA Client: _____

Signature: _____ Date: _____

Name of Guardian: _____

Signature: _____ Date: _____

CPAA Representative: _____ Date: _____

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