



**L.I.G.H.T Application Form**

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Please fill out the following information to the best of your knowledge

<b>Name of Client:</b> _____
<b>Date of Birth:</b> _____
<b>Gender:</b> _____
<b>Address:</b> _____
<b>Telephone:</b> _____
<b>Email Address:</b> _____
<b>Primary Contact 1:</b> Name: _____ Email: _____ Phone: _____
<b>Primary Contact 2:</b> Name: _____ Email: _____ Phone: _____
<b>Legal Guardian:</b> _____
<b>OHIP #:</b> _____

**Only if applicable:**

Referring Agency and/or social worker: \_\_\_\_\_  
(ie. CAS, Service Coordination etc)

**Medical Information:**

**Is the individual diagnosed with any of the following? Please check all that apply:**

<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Autism Spectrum Disorder
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> ASD (Hearing Impairment)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Condition
<input type="checkbox"/> Downs Syndrome	<input type="checkbox"/> Visual Impairment
<input type="checkbox"/> Spina Bifida	<input type="checkbox"/> Oppositional Defiant Disorder (ODD)
<input type="checkbox"/> Pervasive Developmental Disorder	<input type="checkbox"/> Obsessive Compulsive Disorder (OCD)
<input type="checkbox"/> Asthma or Respiratory concerns	<input type="checkbox"/> Attention Deficiency (Hyperactive) Disorder (ADD/ADHD)
<input type="checkbox"/> Communication disorder	<input type="checkbox"/> Tourette's Syndrome
<input type="checkbox"/> Seizure Disorder	
<input type="checkbox"/> Chronic Pain	
<input type="checkbox"/> Other:	

**Food and Non Food Allergies/ Food restrictions:**

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**Does the individual use any of the following? Please check all that apply:**

<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Earplugs
<input type="checkbox"/> Shunt	<input type="checkbox"/> Catheter
<input type="checkbox"/> Tubes (in ears)	<input type="checkbox"/> EpiPen
<input type="checkbox"/> Jogger	<input type="checkbox"/> Hearing Aids
<input type="checkbox"/> Tera Track	<input type="checkbox"/> Inhaler
<input type="checkbox"/> G-Tube	<input type="checkbox"/> Orthotics
<input type="checkbox"/> Adapted flotation device	<input type="checkbox"/> Glasses/ Contacts
<input type="checkbox"/> Helmet for daily use	
<input type="checkbox"/> Other:	

If the individual uses a wheelchair, are there any concerns you feel we should be aware of, such as recent operations, illness, skin rashes etc.?

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**If the individual requires supportive lifting, please provide their height and weight: \_\_\_\_ ft  
\_\_\_\_, \_\_\_\_\_ lbs.**

Does the individual wear ear plugs for water activities?

<input type="checkbox"/> No	<input type="checkbox"/> Right Ear	<input type="checkbox"/> Left Ear	<input type="checkbox"/> Both
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Does this individual require access to any of the following during their stay?  
(Check all that apply)

- Hoyer Lift
- Commode
- Roll in Shower
- Other: \_\_\_\_\_

Please describe any specific routines, supports, or setup needs:

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Please describe any pertinent medical information or present treatments you feel we should be aware of (recent medical procedures, illnesses, rashes etc.)

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**Please list all medications, including dosage and frequency:**

Please enclose all medication bottles with original prescription labels in a sealed Ziploc bag with the individual's name and medication sign off sheets (if available)

Medications	Dosage	Method of administration (oral, cream etc) + with what (water, applesauce etc.)	Time	Reason for taking

**Transportation:**

Can this individual sit independently:

- Yes
- No

Does this individual require assistance and/or additional restraints for safety? (I.e. belt, harness, adapted seats, wheelchair tie downs etc.)

- Yes
- No

If yes, please explain:

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Does your individual use Para Transportation? Do they require an attendant?

- Yes
- No

**Para Transportation #:** \_\_\_\_\_

## Daily Living and Communication

How does the individual communicate? Please check all that apply

<input type="checkbox"/> Functional Speech <input type="checkbox"/> Gestures <input type="checkbox"/> Leading/pointing <input type="checkbox"/> Sign Language (ASL) <input type="checkbox"/> Other:	<input type="checkbox"/> Picture Exchange Program (PECS) <input type="checkbox"/> Isolated Sounds <input type="checkbox"/> Pic- SYM
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Is this individual capable:

Responding appropriately to supervision	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Being responsible for their own belongings	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Participating in a group	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Carrying out tasks when shown how	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eating socially in a group	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Following simple instructions	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Self-Care Abilities:

Task	Independent	Needs some help	Dependent on staff
Dressing/ Undressing			
Washing hands			
Sitting			
Walking upstairs/hills			
Swimming			
Toileting			
Menstrual Hygiene			

Is the individual toilet trained?

- Yes
- No

Does the individual wear diapers or other personal care items?

- Yes
- No
- Night time only
- Menstrual Cycle only

Describe the support the individual needs in toileting/changing:

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Describe the level of support the individual needs for showering and maintaining personal hygiene:

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### **Behaviour Supports and Safety Needs**

Does the individual experience challenges in group settings?

- Yes
- No

When does it most often occur and how do you recommend we respond?

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Please list potential safety problems for this individual in a community setting (ie. wandering, water, fear, busy and/or noisy environments, etc.) and how do you recommend we respond?

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Does this individual experience behaviour/social difficulties? (ie, physical aggression to self, others, or property, tantrums, running away, fire setting?)

- Yes
- No

When does it most often occur, and how do you recommend we respond?

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Does the individual have a history with substance abuse (ie.drugs, alcohol, misuse of prescription drugs etc)?

- Yes
- No

If yes, please explain:

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Does this individual have issues around bedtime routine and/or sleeping through the night?

- Yes
- No

If yes, please explain how you recommend we respond:

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Is there a risk of the individual exploring, wandering, or entering others rooms throughout the night?

- Yes
- No

If yes, what is done at home to prevent this?

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Can this individual share a room with 1 other person of the same gender?

- Yes
- No

Does this individual have any history of inappropriate behaviour towards others?

- Yes
- No

If yes, please explain:

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What, if anything, triggers the behaviours listed above. How do you recommend we support the individual?

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**Additional Supportive Information**

What level of support does the individual receive at school/ day programs/ community outings?

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**Please list some of the individuals favourite and least favourite activities:**

Favourite	Least Favourite
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<hr/>	<hr/>
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**Please share any additional details that would help us support this individual effectively.**

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**I have reviewed this form and completed it to the best of my knowledge and beliefs**

\_\_\_\_\_  
Parent/Guardian/Social Worker  
Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please send application to [light@sonshinefamilies.ca](mailto:light@sonshinefamilies.ca)