

Child's Name:	Signatory Initials:
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Thank you for applying to our Conductive Education® (CE) program through March of Dimes Canada. CE is an innovative learning system – with a core belief in neuroplasticity – that merges the elements of education with rehabilitation. The system deals not only with the physical needs, but also with the social and psychological issues facing people of all ages with neurological conditions. We help children with cerebral palsy and other developmental disorders improve their daily living skills and independence in a fun and positive atmosphere.

A completed application form is required for each child that attends the CE program. Conductors use this information to assess and place the child in the appropriate group and to prepare the task series for each child in advance of their attendance. All information collected will be kept confidential. Please print the child's name and the signatory initials on the top of each page.

How do I get my child involved?

- After submitting this application form a member of the CE team will contact (contact information is listed below) you to set up an initial consultation.
- At the initial consultation the team will meet with you and your child to explain more about the CE program. At the consultation we will go through a series of movements to see where your child is with their learning, and talk about aims that can be set for them if you choose to attend the program. There is a \$50 fee for this consultation. A full consultation report is written and will be shared with you.
- If you decide to attend CE sessions you will be reimbursed the consultation fee. The child group rate is currently \$39.70 and individual rate is \$48.50 per hour. The CE team will determine whether a group or individual session is most appropriate for your child.
- CE is currently not covered by health and insurance plans.

This application will require you to formally sign off on several key components. Please use the checklist below to ensure that your application is complete to timely processing:

- Medical Information, Immunizations & Allergies – Pages 2 and 3
- Hip Agreement – Page 8
- Liability, No Action, Indemnity Release – Page 9
- Privacy Statement & Release of Information – Page 10
- First Aid Cupboard – Page 11
- AFO Agreement – Page 12

Where are CE Sessions held? Toronto, ON



This form can be mailed, faxed or emailed to our CE team at:

Mail:
 March of Dimes Canada
 Conductive Education® Program
 10 Overlea Boulevard
 Toronto, ON M4H 1A4

Fax: 1-416-425-1920, Attention: Conductive Education® Team
Email: ce@marchofdimes.ca
Phone: 1-800-263-3463 / 416-425-3463, ext. 7259



Child's Name:	Signatory Initials:
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Child's Information

First Name:	Initial(s):	Last Name:
Name Commonly Used:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:		
City:	Province:	Postal Code:
Date of Birth (mm/dd/yy):	Health Card No.:	Version Code:
Child lives with: <input type="checkbox"/> Parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardian(s)		

Parent(s)/Guardian(s) Information

Mother/Guardian Name:	Father/Guardian Name:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Cell Phone/Pager:	Cell Phone/Pager:
E-mail:	E-mail:
Address: <input type="checkbox"/> same as child or:	Address: <input type="checkbox"/> same as child or:
City:	City:
Province: Postal Code:	Province: Postal Code:

Emergency Contact(s) Information

#1 – Name of Contact:	#2 – Name of Contact:
Relationship to child:	Relationship to child:
Address:	Address:
City:	City:
Province: Postal Code:	Province: Postal Code:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Cell Phone/Pager:	Cell Phone/Pager:
E-mail:	E-mail:



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Medical History

Primary condition(s):	Method of referral to Conductive Education®:
First indication of condition:	Date of diagnosis:

Operations/hospitalizations:

Additional comments (symptoms of condition, secondary conditions, etc.)

History of Pregnancy and Birth Details

Number of children in the family:

Please list all siblings (names and ages):

If twin/multiple, other sibling's condition:

Complications during pregnancy, delivery or post-delivery: Yes – give details below No

Length of pregnancy: Child's weight at birth:

Any breathing problems: Yes No Was oxygen administered?: Yes No
If yes, for how long?:

Tube feeding: Yes No Seizures: Yes No How long was special care required?:

Medication administered/prescribed at birth:

Tests: MRI CAT Scan Other (specify):



Child's Name: Signatory Initials:

Current Health Information

Child's height: Child's weight:

General health: Good Average Poor

Comments:

Give the last approximate dates of immunizations in the chart below:

Table with 6 columns: Immunization, Date (mm/dd/yy) -approximate, Immunization, Date (mm/dd/yy) -approximate, Immunization, Date (mm/dd/yy) -approximate. Rows include Tetanus, Polio, Pertussis, Diphtheria, HIB, Other.

Contractures/dislocations:

Hip X-ray (current or last):

Seizure/epilepsy: Yes No

If yes, please describe frequency, length and type:

Head Development

Circumference: Microcephaly: Yes No

Macrocephaly: Yes No Hydrocephalus (shunt): Yes No

Motor Development (check the most appropriate answer)

Table with 3 columns: Can your child...?, Comments. Rows include Lift his/her head, Crawl, Turn over, Roll, Sit with support, Stand with support, Walk with support, Sit unsupported, Stand unsupported, Walk unsupported, Transfer toys from one hand to the other, Put hands together in midline (clap, clasp), Dominant hand: Right Left.

General Comments:



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Vision

Date of last test:	Where:	Outcome:
Glasses: <input type="checkbox"/> Yes <input type="checkbox"/> No	Laser Surgery: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when:	

Hearing

Date of last test:	Where:
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Comments:

Eating/Drinking

Is your child able to: (a) Chew Yes No (b) Swallow Yes No (c) Finger Feed Yes No

Is there any difficulty with eating, e.g., tongue thrust, bite reflex, lip closure, etc? Yes No

If yes, explain:

Is a special diet required: Yes No

If yes, explain:

Feeding equipment required:

Difficulties when drinking (e.g., dribbling):

Drinking equipment required:

Is there a Speech Therapist's report: Yes No

Communication

First language spoken at home (if other than English):

Method(s) of communication (check all that apply):

Non-verbal Sounds Babbling Words Sentences Signs/ASL

If words/sentences are spoken, what is the clarity:

Clearly understood Some effort required to understand Difficult to understand

Augmentative system (if used):

Level of awareness and interest in other people/activities: High Average Low

Level of attention/concentration: High Average Low

Favourite activities (hobbies, pets):

Least favourite activities:

Comments:



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Behaviour

General demeanor (e.g., generally content, cries a lot, passive, etc.):

Is there any difficulty with sleeping: Yes No

If yes, please describe:

Are daytime naps taken: Yes No

If yes, how many and how long:

Is there a bedtime/naptime routine in place: Yes No

If yes, please describe (sleeping pattern):

Self-Care

Dressing/undressing: Independently With help Cannot dress/undress

Toileting: Uses potty Uses toilet Uses commode chair Wears diapers

Comments:

Current Treatments

Physiotherapy:

Name of Physiotherapist/Clinic:

Address:

Frequency of treatment:	Duration of sessions:
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Speech Therapy:

Name of Therapist/Clinic:

Address:

Frequency of treatment:	Duration of sessions:
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Occupational Therapy:

Name of Occupational Therapist/Clinic:

Address:

Frequency of treatment:	Duration of sessions:
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Other treatments (e.g., CP yoga, swimming, etc.):

Frequency of treatment:	Duration of sessions:
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Social worker: Yes No

Comments:



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Special Aids (check all that apply)

AFOs
 Arm splint
 Brace
 Canes
 Gaiters
 Peidro boots
 Special Chair
 Standing frame
 Walker
 Other:

Education

Nursery school: Yes No School: Yes No Grade:

Playgroup/ E/C group: Yes No

Name of the school/playgroup:

Days and hours of attendance:

Details of attendance at other centres for specific reason, e.g., cranial osteopathy, aromatherapy, reflexology, homeopathy, etc.:

Conductive Education:

What goals would you like to work on?

Medical Information - Immunizations and Allergies

If your child has had any of the following conditions, please check Yes or No and give the approximate date

Condition/Illness	Had/Has	Date of Onset (mm/dd/yy)	Condition/Illness	Had/Has	Date of Onset (mm/dd/yy)
Adenoidectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No		Kidney Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No		Measles, German	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Chicken Pox	<input type="checkbox"/> Yes <input type="checkbox"/> No		Measles, Red	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No		Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No		Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Frequent Colds	<input type="checkbox"/> Yes <input type="checkbox"/> No		Severe Stomach	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No		Tonsillectomy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No		Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hernia Repair	<input type="checkbox"/> Yes <input type="checkbox"/> No		Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	



Program Application Child Conductive Education® Program

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Allergy	Details / Comments
<input type="checkbox"/> Carries Epi-pen:	
<input type="checkbox"/> Carries Ana kit:	
<input type="checkbox"/> Bee Stings:	
<input type="checkbox"/> Animals – identify:	
<input type="checkbox"/> Food – specify:	
<input type="checkbox"/> Penicillin:	
<input type="checkbox"/> Latex:	
<input type="checkbox"/> Other drugs – specify:	
<input type="checkbox"/> Other – specify:	

State any other physical or emotional concerns or other information that the Conductors may need to know *(use an additional sheet if necessary)*:

I hereby state that the above information is true to the best of my knowledge

Parent signature:	Date:
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Hips

- To my best knowledge, my child's hips are in place and functioning satisfactorily
- I give permission for my child to be involved in all task series which are potentially important facilitators in his/her learning process
- If there are any movements which you are aware of that may be harmful or painful for your child, you are required to inform the Conductors prior to the start of the program.

Name of signatory:	Relationship to child:
Signature:	Date:
Conductor's signature:	Date:

Liability, No Action, Indemnity Clauses: Release

Please read and sign the following Exclusion of Liability, No Action and Indemnity clauses. By signing below, you will waive certain legal rights, including the right to sue. Please read carefully.

- In consideration of the services to be provided to me by March of Dimes Canada, I hereby agree as follows:
- EXCLUSION OF LIABILITY**--not to hold March of Dimes Canada, their members, directors, volunteers, officers, agents, representatives, employees, or assigns ("Releases"), or any of them, liable for any losses, damages or injuries that I may suffer, whether to person or property, howsoever caused, including negligence, breach of contract and breach of any statutory duty or other duty of care, on the part of the Releases, or any of them;
 - NO ACTION**--not to bring any action, proceedings or claims against the Releases, or any of them, for any losses, damages or injuries that I may suffer, whether to person or property;
 - INDEMNITY**--to indemnify and hold harmless the Releases and each of them from and against all claims, actions, costs, expenses and demands brought by any person in respect of death, injury, loss or damage, whether to person or property, resulting directly or indirectly from my participation with the Releases and the delivery of the projects and services of March of Dimes Canada.

Declaration and Signatures

- I have read and understood this agreement, and I am aware that, by signing this agreement, I am waiving certain legal rights which I or my heirs, next of kin, executors, administrators, and assigns may have against the Releases.
- I hereby release and hold harmless all March of Dimes Canada and any and all other funding or organizations and sources, the owners and/or operators of any facilities utilized and any providers/ conductors of instruction, the agents and employees of any of these parties, from all liability and claims for any injuries or accidents to myself, as well any damages from any cause to any personal property that may occur while participating in the said Conduction Education ® Program.

Parent/Caregiver name:	Signature:	Date:
Name of Witness (print):	Signature:	Date:
Name of MODC Representative:	Signature:	Date:

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Privacy Statement

March of Dimes Canada is committed to handling any personal information that we may collect concerning you and your family member(s) in a professional, respectful, and lawful manner. March of Dimes Canada collects, uses, and discloses personal information in accordance with this privacy statement and our privacy policy. The personal information about you and your family member(s) is used for the purposes of:

- i) contacting you about the status of your application(s)
- ii) obtaining feedback about March of Dimes Canada services you receive
- iii) providing information about March of Dimes Canada to you and others
- iv) complying with the laws and regulations that require the collection, use and disclosure of personal information in connection with the Assistive Devices program

The personal information collected about you and your family member(s) includes information supplied by you in your application for funding assistance and any additional or updated information which we may collect from you in the future.

Release of Information

March of Dimes Canada is pleased to provide you with service. From time to time we are interested in receiving your feedback and would like to send you information to help us better serve you. Our Quality Service policy is:

“to ensure that anyone affiliated with March of Dimes Canada recognizes all internal and external contacts as customer and is committed to delivering Quality Service to each and every one of them”

In order to conduct satisfaction surveys or to tell you about other services, we request your permission to contact you. In the future, we may like to contact you for one of more of the reasons listed below. This will help us continue to offer you quality service and respect your privacy and personal wishes. Thank you for your assistance.

I agree that March of Dimes Canada may contact me for the following reasons: (check all that apply)

- To obtain feedback on services I receive from March of Dimes Canada.
- To advise me of new information or services that may be of interest to me.
- To provide me with a volunteer opportunity.
- To solicit my view on services or policies affecting people with disabilities.

Parent/Caregiver name:	Signature:	Date:
Name of Witness (print):	Signature:	Date:
Name of MODC Representative:	Signature:	Date: