Cerebral Palsy ALBERTA
Life Without Limits

CLIENT INTAKE FORM

All information collected from the Client Intake Form assists Cerebral Palsy Alberta (CPAA) in planning and implementing safe and quality programs and support services. Information will only be disclosed to CPAA personnel. Names and photos may be used in promotional documents for CPAA, only when permission has been granted.

Office Use Only	**Application Date:**	**Client #:**

Client Last Name:	**First Name:**	
Gender Identity:	**Pronoun:**	**Date of Birth (MM/DD/YYYY):**
Street Address:		
City:	**Province:**	**Postal Code:**
Home Phone:	**Cell Phone:**	
Email:	**Access Calgary ID / Edmonton DATS #:**	

Current Living Arrangement

☐ **Lives with Family**	☐ **Lives Independently**	☐ **Supportive Roommate**	☐ **Staffed/Group Home**
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:**	
Type of Guardianship:	☐ **Self-Guardian**	☐ **Public Guardian**	☐ **Legal Guardian**
Type of Trustee:	☐ **Self-Trustee**	☐ **Public Trustee**	☐ **Legal Trustee**

Emergency Contact Information (Other than Guardian or Home Contact)

Last Name:	**First Name:**
Relationship to Client:	
Home Phone:	**Work Phone:**
Cell Phone:	**Email:**

Client Medical Information

Disabilities:	
Please Describe Client's Disabilities:	
Medical Conditions:	
Alberta Health Care No.:	
Allergies:	**Allergy Kit Needed? :**
Doctor's Name:	**Doctor's Number:**
Other Medical Supports (OT/PT/SLP):	
Name:	**Contact Number:**
Name:	**Contact Number:**
Name:	**Contact Number:**
Does the Client Have a History of Seizures?	☐ **Yes** ☐ **No**

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

Please note any technical aids client may use:

Wheelchair/Scooter:	**Braces/Crutches/Walker:**
Communication Device:	**Braille:**
Sign Language:	**Hearing Aid:**

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 (behaviour plan, triggers, etc):			

Support Information

Type of Funding:	
☐ **Private** ☐ **Indigenous Services** ☐ **Other**	
☐ **Persons with Developmental Disabilities (PDD)** **Type of Service:**	
Contact Name:	**Contact Number:**
Email:	
☐ **Assured Income for Severally Handicapped (AISH)** **Type of Service:**	
Contact Name:	**Contact Number:**
Email:	
☐ **Family Supports for Children with Disabilities (FSCD)** **Type of Service:**	
Contact Name:	**Contact Number:**
Email:	

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:** _____

About Cerebral Palsy Alberta:
Cerebral Palsy Alberta (CPAA) is a registered non-profit organization that serves the disability community in the Province of Alberta with offices in both Calgary & Edmonton. The CPAA makes a difference in the community by enriching the lives of people with cerebral palsy and other disabilities. Through our programs and services, we promote awareness, acceptance and understanding for persons with disabilities to live Life Without Limits. For more information about the organization and to learn about ways you can support Life without Limits, please visit www.cpalberta.com.

Permission for Photography/Videography

I (we) hereby give CPAA permission for _____ 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.

I (we) hereby understand that my (our) name and/or photo may be displayed throughout the course of instructional programs/classes, if applicable, and that the session I (we) may be participating in will be recorded and stored on a secure CPAA site and accessible to vetted individuals to be viewed later.

_____ _____

Signature of parent/guardian/Client Date

_____ _____

Signature of witness Date

☐ **Permission declined**

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Release

In agreeing to this release, I (we) acknowledge the intent thereof and I (we) agree and absolve and hold harmless Cerebral Palsy Alberta (CPAA), corporate sponsors, cooperating organizations, instructors, volunteers, staff and any other parties connected with CPAA in any way singly or collectively from and against any blame or liability for any injury, misadventure, harm, loss, inconvenience or damage hereby suffered or sustained as a result of participation in a CPAA program, service, event or any activities associated herewith.

Freedom of Information Protection Act

The undersigned, in accordance with FOIP (Freedom of Information Protection Act), acknowledges that any client information collected, nature of client involvement with a program, service, event or activity including any interactions will be kept strictly confidential. In the event of disclosure or indication of harm, current, potential, or future, the undersigned acknowledges and understand that CPAA, staff, and assigned volunteers are required by law to report this to the appropriate authorities. No person shall participate in any CPAA activity, event, service, or program by without reading and agreement to these terms.

Indemnification

The undersigned further agrees to completely indemnify CPAA for any expenses or liabilities because 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, event, service or activity. The undersigned also represents that full disclosure of the client's medical history has been made known to Cerebral Palsy 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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