

KW Habilitation Services: *Dept. of Kinesiology*

115 University Ave. E., Waterloo, N2J 2W1

Request for Service

Child: *First Name:* _____ *Last Name:* _____

Date of Birth: day _____ month _____ year _____

Parent(s) / Legal Guardian(s) _____

Phone #: _____

Name of Child Care Centre: _____

Contact Person @ Child Care Centre: _____

Phone #: _____

Days the child attends day care:

Mon. Tues. Wed. Thurs. Fri. // AM PM Full Day

Please describe issues for which the child is being referred:

Contraindications: _____

Name of person making referral: _____

Contact Information: Phone Extension: _____ E-mail: _____

Date of referral: _____

Please fax or mail this form, along with the completed parental forms to:

Brad Simpson
Manager of Kinesiology Dept.
KW Habilitation Services
115 University Ave. East
Waterloo, Ontario
N2J 2W1
Fax# 519-884-8609

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115 University Ave. E., Waterloo, N2J 2W1

Dear Parent(s) / Legal Guardian(s),

The following information is provided to support your consent for Kinesiology Services.

What are Kinesiology Services?

- A service for children and providers in licensed child care programs.
- Addresses physical development, by providing activities and suggestions to child care providers on how to facilitate your child's development.
- Provides suggestions and, when applicable, equipment, to allow your child to participate in all aspects of the program.
- A resource to child care providers, to problem solve issues regarding physical development and adapting the environment if necessary.
- Provides training to the child care providers regarding back care and lifting.

How does this service work?

- After consent is signed, the kinesiologist will schedule a visit to the child care centre.
- Information is gathered from the referral source, from discussion with child care provider(s), from you, the parent, and from observing your child. To best serve your child, it is important for you to share any available reports with the kinesiologist.
- Depending on the nature of the issues, activities will be provided to help the child develop joint stability, muscle strength, postural control, balance, gait (walking), sensory & information processing, or motor planning (how people move). Informal assessment is always ongoing to be sure we are optimizing the child's abilities.
- Activities or exercises will be provided. When necessary, equipment may be recommended or provided and changes within the class / play areas may be suggested.
- A written program with recommendations will be given to the child care centre, and a copy will be given to you.
- The child will be monitored and adjustments will be made to activities as required.

Name of child: _____

I understand the information stated above and consent to my child being assessed and resulting information being shared with child care providers at _____ child care centre.

I consent to the kinesiologist sharing information regarding my child at case sharing meetings.

I consent to the kinesiologist sharing information regarding my child, with relevant health care providers, resource consultants, and other involved people. My consent extends to the following people:

| NAME | POSITON | AGENCY |
|------|---------|--------|
| | | |
| | | |
| | | |
| | | |
| | | |

I understand that I may call the kinesiologist at any time to ask questions or express concerns. (519-884-8080 ext. 230)

I understand that I may remove my consent for all or part of a service, or any communication about my child.

Printed name of Parent(s) or Legal Guardian(s)

Witness

Signature of Parent(s) or Legal Guardian(s)

Date

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Child: *First Name:* _____ *Last Name:* _____
Date of Birth: day _____ month _____ year _____

Contact Information: (please fill out only your preferred method(s) of contact)

Phone #: _____ *Cell Phone #:* _____

e-mail : _____ *Other :* _____

Other's involved with child:

| DOCTOR | SPECIALTY | FREQUENCY SEEN |
|--------|-----------|----------------|
| | | |
| | | |
| | | |
| | | |

| PROFESSIONAL | NAME | AGENCY | FREQUENCY SEEN |
|------------------------|------|-------------|----------------|
| Physiotherapist | | KidsAbility | |
| Physiotherapist | | Private | |
| Occupational Therapist | | KidsAbility | |
| Occupational Therapist | | Private | |
| | | | |
| | | | |

Note: *If you have any reports from any of the above professionals that you wish to share, they may be forwarded to the kinesiologist.*

Please describe your concerns regarding your child's physical development and/or participation in the child care program that he/she is enrolled in:

(Signature of parent(s) / legal guardian(s))

Date