

## Learning Day Program

Community of Hearts Lifelong Learning Centre offers the educational Learning Day Program that runs from January to December. The centre will be closed for all statutory holidays and the last week of December.

Tuition Fee: \$61.00/day including lunch meal

### Payment Breakdown:

1. Payment is due the first day of each month. Invoices will be provided prior to the beginning of each semester and receipts will be provided twice a month to allow participants to submit paperwork to Passport Funding agencies.
2. Semesters are as follows:
  - a. January, February, March, and April
  - b. May, June, July, and August
  - c. September, October, November, and December
3. Passport Funding can be used towards the cost of tuition. It is the responsibility of program participants to submit their receipts from Community of Hearts to their local Passport Funding agency for reimbursement.
4. Refunds: available to participants who are permanently withdrawing from program. Participants are required to provide two weeks notice of the termination date. No “make-up” days or refunds will be granted for absenteeism or inclement weather.

To register for Community of Hearts’ Learning Day Program, complete the following forms:

- ✓ Program Participant Expectations
- ✓ Personal Information Profile
- ✓ Transportation Agreement
- ✓ Photography & Social Media Release
- ✓ Permission to Administer Medication

Please contact Community of Hearts Lifelong Learning Centre at 519-826-9056 or [info@communityofhearts.ca](mailto:info@communityofhearts.ca) if you require support to complete the enclosed forms, and to answer any questions/concerns you may have.

Sincerely,  
The Community of Hearts Team

## Program Participant Expectations

### Independent:

- ✓ Participates fully without intense levels of supervision
- ✓ Able to walk, eat and toilet independently
- ✓ Participates in physical activity without support
- ✓ 18+ years of age: adult, has completed available education system programs and demonstrates maturity
- ✓ Possesses communication skills that permit relationship building
- ✓ Desires to learn/perform practical and social activities of daily living

### Ready, Willing & Able to Be Part of a Group:

- ✓ Interacts appropriately in a group and benefits from peer relationships
- ✓ Able to benefit from program and achieve goals set by themselves and their parents/guardians

### Support for Success is Present:

- ✓ Parents/guardians are interested and prepared to be involved in an individual plan for the participants' success
- ✓ Parents/guardians recognize the benefits of independence for the participants; and are capable of being flexible and accept uncertainties along the learning journey
- ✓ Parents/guardians are willing to partner with staff and volunteers in the best interests of the participant

### Program/Group Compatibility:

- ✓ In order to assess the needs of the participant and to determine the capacity of the staff to meet those needs, there will be a ninety working day probationary period for each participant. Following this probationary period, parents/guardians, the participant, and staff will meet to discuss next steps.

I, the undersigned, have read and understood the information above outlining the expectations of my participant in program. I have read and understood the expectations outlined for myself, as part of the support team for my participant.

Parent/Guardian Signature: \_\_\_\_\_

**Personal Information Profile**

Participant’s Name: \_\_\_\_\_  
First Middle Last

Preferred Name: \_\_\_\_\_

Preferred Pronouns: \_\_\_ He/Him \_\_\_ She/Her \_\_\_ They/Them

Date of Birth (yyyy/mm/dd) \_\_\_\_\_

**Participant Availability** (please indicate the days of the week your participant will attend program)

Monday (9AM - 3PM)	Tuesday (9AM - 3PM)	Wednesday (9AM - 3PM)	Thursday (9AM - 3PM)	Friday (9AM - 3PM)

Parent/Guardian: \_\_\_\_\_

Home #: \_\_\_\_\_ Other #: \_\_\_\_\_

Street Name: \_\_\_\_\_

Apartment/Suite #: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Place of Employment (if applicable): \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Home #: \_\_\_\_\_ Other #: \_\_\_\_\_

Street Name: \_\_\_\_\_

Apartment/Suite #: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Place of Employment (if applicable): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone #: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_

## Learning Day Program

### Medical Contact

Family Doctor's Name: \_\_\_\_\_

Office #: \_\_\_\_\_

Office Address: \_\_\_\_\_

Are all immunizations up to date? \_\_\_ Yes \_\_\_ No

Outstanding immunizations? Please explain: \_\_\_\_\_

\_\_\_\_\_

### Allergies

Please list all allergies: \_\_\_\_\_

\_\_\_\_\_

What physical signs indicate an allergic reaction? \_\_\_\_\_

\_\_\_\_\_

Treatment? \_\_\_\_\_

\_\_\_\_\_

### Medical History

Please describe the participant's condition, any signs/symptoms to be aware of: \_\_\_\_\_

\_\_\_\_\_

Is treatment required for any of the following conditions? :

Seizures: \_\_\_\_\_

Respiratory Needs: \_\_\_\_\_

Circulatory/Cardiac Needs: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

### Nutrition

Dietary requirements: \_\_\_\_\_

\_\_\_\_\_

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**Applicant's Current Capabilities** (please indicate)

Communication	Receptive Speech	Understands multi-step instructions	___
		Understands step by step instructions	___
	Expressive Speech	Uses complete sentences	___
		Uses words/short phrases	___
		Uses sounds/gestures	___
		Uses ASL	___
		No communication	___

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Mobility	Independent	___
	Needs help with stairs	___

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Supervision Required		
Capable of independent seatwork	Rarely	___
	Sometimes	___
	Often	___
Completes tasks without supervision	Rarely	___
	Sometimes	___
	Often	___
Works well in small group setting without supervision	Rarely	___
	Sometimes	___
	Often	___

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Learning Day Program

Please provide any details that may be helpful to supporting your participant in program:

Hobbies? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fears? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Triggers? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fixations? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In the case that the participant becomes distraught/escalated, please describe strategies used at home and in other programs that support and deescalate the participant:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Transportation Agreement

Participant Name: \_\_\_\_\_

I, parent/guardian of the participant named above, give permission for Community of Hearts Lifelong Learning Centre staff/volunteers to provide transportation. Excursions/community activities will be within, as well as out of, Guelph Wellington County.

I understand the risks involved with such activities and will not hold Community of Hearts Lifelong Learning Centre or any of their staff/volunteers/board members responsible should any type of injury, accident, damages or problems occur.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### Photography & Social Media Release

I, \_\_\_\_\_, do hereby give my consent for photographs/videos to be taken of me by the staff and volunteers of Community of Hearts Lifelong Learning Centre and used on the organization's website, and social media platforms.

I fully understand that these photos/videos may identify me as a person involved with Community of Hearts Lifelong Learning Centre and in turn may identify my disability.

### Permission to Administer Medication

I/we, \_\_\_\_\_  
are the parents/guardians of \_\_\_\_\_, a  
participant at Community of Hearts Lifelong Learning Centre.

I/we, hereby authorize the staff person to administer medication supplied by –or for- the participant.

In giving my/our authorization, I/we agree to bring no action whatsoever or assert any cause of action whatsoever by reason of any alleged act of negligence, breach of the contract of statutory duty, or other cause of action known to law against Community of Hearts Lifelong Learning Centre or by any of its staff by reason of any failure to administer such medication, or by reason of any act whatsoever relating to the use of the aforesaid medication.

I/we further agree to indemnify and save harmless Community of Hearts Lifelong Learning Centre and any of its agents, employees, administrators or assigns, for any claims that may be made by or on behalf of the said individual by reason of any alleged act of negligence, breach of the contract or statutory duty, or cause of action known to law against Community of Hearts Lifelong Learning Centre, any of its agents, employees, administrators, or assigns, by reason of the administering of the said prescribed emergency medication, or by reason of any failure to administer such medication or by reason of any act whatsoever relating to the use of the aforesaid medication.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_