

**APPLICATION FOR KIN ENTERPRISES INC.
300 - 15th Avenue East, Prince Albert, SK. S6V 2N7**

TO BE COMPLETED BY APPLICANT, PARENT OR CAREGIVER:

Name of Applicant _____

Self Referral _____ Yes _____ No

Referring Agency _____ Contact Person _____

Funding Agency _____ Contact Person _____
(Community Living Division, DCR, INAC, Band, SGI, Other)

Other Agency involved: _____

Present Address _____ Phone No. _____

Date of Application _____

Date of Birth _____ S.I.N. _____

Treaty Number if applicable _____ Band _____

Hospitalization No. _____

Physician _____ Clinic _____

Address if application is accepted: _____ Phone No. _____

Name of parent or guardian _____ Phone No. _____

In case of emergency contact _____ Phone No. _____

First Alternate contact _____ Phone No. _____

Second Alternate Contact _____ Phone No. _____

Last School Attended _____ Grade Completed _____

List skills and interests you may have _____

Have you ever been employed, if so where? _____

List positions held, nature of work and dates: _____

What hobbies or outside interests do you have? _____

Have you had a tour of KIN Enterprises Inc.? _____ Yes _____ No

Based on the information you have received, what program area do you prefer?

Date Received

Signature of Applicant

Signature of Guardian

**MEDICAL REPORT FOR KIN ENTERPRISES INC.
300 - 15th Avenue East, Prince Albert, Sk S6V 2N7**

TO BE COMPLETED BY THE APPLICANTS PHYSICIAN:

Patients Name _____ Age _____ Sex _____

Address _____ Postal Code _____

Hospitalization No. _____ Medical Services No. _____

How long has the patient been under your care? _____

DIAGNOSIS and/or STATEMENT OF PRESENT DISABILITY (include date of onset):

OTHER DISABILITIES: _____

MEDICATIONS:

DOSAGE:

TIME INTERVALS:

Is supervision of Medication required? Yes _____ No _____

Are there any known Allergies? _____

Seizures Yes _____ No _____ Type and Frequency _____

Special Diet? _____

History of Ear, Nose & Throat Infections? _____

History of T.B. or contact with T.B.? _____

HEPATITIS "B" - HBsAg+ ()

- HBsAg- ()

(NOTE: Hepatitis B status is required to determine if other participants require vaccination. A positive reaction will not prevent admission to the program.)

HEARING: Right ear _____ Left Ear _____

VISION: Right Eye - 20/ _____ With Glasses - 20/ _____

Left Eye - 20/ _____ With Glasses - 20/ _____

DOES PATIENT USE:

Wheel Chair _____ Full time _____ Part time _____

Crutches _____ Full time _____ Part time _____

Day Brace _____ Full time _____ Part time _____

Hearing Aid _____ Cane _____

Artificial Limbs _____

IS THE PATIENT:

Physically fit for gainful employmentYes _____ No _____

Capable of using public transportationYes _____ No _____

Capable of climbing stairs Yes _____ No _____

Is the Patient free of Communicable Diseases? Yes _____ No _____

Name of Physician

Date

Print or Type

(Signature of Physician)

Phone: Office _____

Address: _____

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(PLEASE USE REVERSE SIDE FOR ANY FURTHER COMMENTS)

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TO BE COMPLETED BY THE REFERRING AGENCY:

Name _____ Date _____

Address _____ Phone no. _____

Parent(s) _____ Phone No. _____

Address _____ Cell No. _____

Care Provider if applicable _____ Phone No. _____

Address _____ Cell No. _____

Day Contact No. _____ Cell Phone No _____

Diagnosis, any extra care required _____

Seizures yes _____ no _____ type and frequency? _____

Psychiatric examinations _____ Date(s) _____

Institutional Admissions _____ Date _____

Last Assessment (for developmental education purposes and daily living needs) summary _____

Has an assessment been provided for funding purposes? _____ Yes _____ No

Level of Supervision required _____

Required Behavioral Supports _____

Medical Needs _____

Dietary Needs _____

Goals for the individual, (Please prioritize) _____

Case Manager (if applicable) _____ Phone no. _____

Agency _____

Address _____

_____ Date _____

Date _____ Signature _____

Information is available regarding a list of options for programs at KIN Enterprises Inc., community supports, places to go for assessments and the role of Community Living Division if required. Please phone 953-4124 for further information.