APPLICATION FOR KIN ENTERPRISES INC.
PRINCE ALBERT, SK. S6V 2N7

Name ____Date_______________

Address ____Phone No. _________________

Date of Birth __________________________________S.I.N. ________________________

Hospitalization No. ________________________Doctor ___________________________

Treaty Number ___________________________Band ____________________________

Address if Accepted ___________________________________Phone No. ____________

In case of emergency contact ____________________________Phone No. ____________

Guardian/Caregiver if accepted: ____

Referring Agency ____

Social Worker ____

Last School Attended______________________________Grade Completed____________

Age Started School _____________________Age Leaving School ___________________

List any skills you may have ____________ _____________________________________

____

Have you ever been employed ________________________________ ________________

If yes, list positions held, nature of work and dates:

____

What hobbies, sports and outside interests do you have? ____________________________

____

____

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

____

_____________________________ ___________________________________

Date Received Signature of Applicant

MEDICAL REPORT FOR

KIN ENTERPRISES INC.

TO BE COMPLETED BY THE APPLICANTS PHYSICIAN AND RETURNED TO:
Kin Enterprises Inc.
300 - 15th Avenue East, Prince Albert, Sk S6V 2N7

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 know 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 employment ....Yes ______No_________
Capable of using public transportation ......Yes ______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:____

(PLEASE USE REVERSE SIDE FOR ANY FURTHER COMMENTS)

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

TO BE COMPLETED BY THE REFERRING AGENCY:

Name ____ Date ________________

Address ______________________________ Phone no. ________________________

Next of kin __________________________ Address __________________________

Father _______________________________ Age _____________________________

Address ______________________________ Occupation _______________________

Mother _______________________________ Age _____________________________

Address ______________________________ Occupation _______________________

Siblings: (List from oldest to youngest)

Name age address

____

____

____

____

Disability, abnormalities, extra care needed - explain: __________________

____

____

Seizures yes ______no______ type and frequency? _________________________

Psychiatric examination or institutional admissions: ______________________

Dates:____

____

List childhood illnesses, diseases and serious injuries: ___________________

____

____

____

Brief assessment of personality (disposition and temperament): _______________________

____

____

____

Diet Problems:____

____

Assessment to date: (Psychologists summary) or other: ______________________________

____

____

Goals or objectives for the individual: ____

____

____

Case manager ____________________________________Phone no. ____________________

Position _________________________agency ______________________________________

Address ____Date _____________________

Signature ____