CAPE

Center for **A**dults in **P**rogressive **E**mployment
40 Lower MacLean Street, Glace Bay NS, B1A 2K7
Phone: 849-8187 or 849-3798, Fax: 849-3798
E-mail: cape@ns.sympatico.ca

ADMISSIONS

Attached is the application package that you requested. If possible it should be filled out in consultation with a parent/ guardian, teacher, social worker, or instructor. The Medical Report should be filled out by the examining physician and mailed directly to the Executive Director. When all documentation is received the Executive Director will review the application. A meeting will be arranged for the applicant to view the facilities and address any final questions about the application. Acceptance is based on availability of space in the appropriate program. Until such time individuals are placed on a wait list prioritized by the date of application. If you have any questions or concerns, please do not hesitate to contact me at the above number.

Lynne McCarron

Executive Director

APPLICATION FOR ADMISSION TO CAPE

I _____ hereby make application for _____ to participate in programs offered by CAPE. I give permission to the Executive Director to obtain relevant information from past educational Facilities, Vocational Centers, group Homes, etc. If accepted, I agree to adhere to the Policies and Procedures of CAPE.

_____ _____
Applicant's Signature Parent/ Guardian Signature

_____ _____
Date Telephone Number

Name of Applicant: _____
Surname Given Middle

Address: _____
Street Town Postal Code

Phone #: _____ Date of Birth: _____

Social Insurance Number: _____

Family Doctor: _____

Health Card #: _____ Expiry: _____

Nature of the Disability: _____

Independent Toileting skills: Yes___ No___

Living Arrangements: Dependent___ Independent___ Supervised___
Group Home ___ Other___ please state_____

Verbal: ___ Nonverbal: ___ Mobile: ___ Wheelchair: ___

Parent or Guardian's Address (if different from above)

_____
Street Town Postal Code

_____
Parent/ Guardian's Signature

Education:

School:

1. _____ Grade Completed_____

2. _____ Grade Completed_____

Vocational Center:

1. _____ Years Attended_____

2. _____ Years Attended_____

References:

1. _____ Phone # _____

2. _____ Phone # _____

List of Current Medication:

Name X's Daily Dosage

- _____
- _____
- _____
- _____
- _____
- _____

Known Allergies:

_____
_____
_____

Special Concerns:

_____
_____
_____
_____

Emergency Contact Person: _____ Phone: _____

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TO BE COMPLETED BY EXAMINING PHYSICIAN

_____ , is an applicant to CAPE. We are required to have medical information on each applicant in order to assess the ability of the services provided by the facility to meet the needs of the applicant. CAPE is an Employment Training and Opportunity Center for individuals who have a mental, physical, or social challenge. Our services range from Pre-Vocational to Community Employment Training. Each of these services meet a variety of needs and are geared to the individual in order to allow the participant to achieve their highest potential. Please complete the enclosed report and forward to the above address as soon as possible.

Thank you for your co-operation,

Sincerely,

Lynne McCarron
Executive Director

APPLICATION FOR ADMISSIONS MEDICAL REPORT
CONFIDENTIAL
PLEASE PRINT

NAME:

ADDRESS:

DATE OF BIRTH:

FAMILY PHYSICIAN:
ADDRESS:
PHONE NUMBER:

1.BriefMedical History:

2. List any present medication and dosage:

3. List primary and secondary diagnosis:

4. Previous/Ongoing Illness/Conditions Applicant is subject to:

5. Present Health Problems:(Please specify any present treatment and/or recommendations):

6. Physical Conditions:

Height:

Weight:

Vision:
Date last checked:
Hearing:

Date last checked:

	Yes	No	COMMENTS
1) Diabetes			
2) Cerebral Palsy			
3) Bronchitis			
4) Asthma			
5) Epilepsy			
6) Convulsions			
7) Mental Illness			
8) Kidney Trouble			
9) Heart Trouble			
10) Eczema			
11) Sore Throat			
12) Frequent Colds			
13) Hay Fever			
14) Abdominal Cramps			
15) MeaslesIRubella			
16) Measles/German			
17) Mumps			
18) Meningitis			
19) Pneumonia			
19) Chicken Pox			
20) Tonsillitis			
21) Appendicitis			
22) Other			

Use of Limbs	Arms		Hands		Legs		Feet	
	R	L	R	L	R	L	R	L
Normal								
Impaired Use								
No Use								
Amputation							I	

Bladder Control yes no

Bowel Control yes no

9. Describe Allergies/Reaction/Treatment(if applicable):

Does this applicant require special care?

Yes No

Comments

Is there any medical or other information you think we may require?

Signature of Physician
