Main Contractual Agreement

Respite Care, Zootherapy & Day Camps
A Leap Towards a Difference!

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ExperienceUnik

Authorization & Consent

The participant will enjoy **UNIK** and **COLOURFUL** experiences!

Participation in our services—Respite Care, Zootherapy, Day Camps, and Farm Visit—requires acknowledgement of the following:

1. **Waiver of Liability**

   This form is mandatory and must be signed by a parent or legal guardian of any participant in our services.

2. **Inherent Risks**

   All participants acknowledge the existence of inherent risks associated with the nature of our activities, which may include accidents or injury. While every effort is made to ensure a safe environment, risks may still arise.

   We ask that all participants follow instructions carefully and remain vigilant during activities. Support and assistance will be provided as needed.

   I, _____, acknowledge and accept that by registering my child for services with Expérience Unik, I am aware of the potential risks involved.

Absence & Delay Policy

- Please notify us of any absence at least 48 hours in advance by calling (613) 266-5244, otherwise fees will apply ($125). This regulation is put in place to allow other people to benefit from an available spot.
- A fee of $5 per 30 minutes will be charged for late pickups.

Payment Information

Payments should be made to Expérience Unik, preferably via e-Transfer. Other methods accepted: inter-institution transfers, cheque, or cash.

- Inter-institution transfer details:
  Transit #: 123
  Institution #: 829
  Account #: 351 663 0
- All payments are due within 30 days.
- Interest will be charged at 2% per month (24% per year) on overdue accounts.

Permission and Medical Information

1. **Photo Authorization**

Do you authorize Expérience Unik to post photos of the participant on our Facebook page?
Yes ☐ No ☐

2. **Medication Administration**

Will the participant require medication during our services? Yes ☐ No ☐

If yes, please specify the name of the medication, dosage, and schedule:

I, _____, (Parent/Guardian), authorize a member of the Expérience Unik team to administer the necessary medication to my child.

3. **Medical Conditions or Specific Needs**

Does the participant have any medical conditions, allergies, or specific needs we should be aware of? Yes ☐ No ☐

If yes, please complete **Annex-1**: *Medical Needs Plan* and/or **Annex-2**: *Anaphylactic Emergency Plan*

Acknowledgement & Consent

I, _____, (Parent/Guardian), confirm that I have read and understood this form.

I give permission for _____ (Participant) to take part in the services provided by Expérience Unik.

Signatures

_____ _____

Parent / Guardian Signature Date

_____ _____

Owner of Expérience Unik Signature Date

Client Record

Photo of the child/adult (recommended)

Personal Information

Name of the participant: _____
Date of birth: _____
Diagnosis (if applicable): _____
Address: _____

Contact Information

Name(s) of the parent(s)/guaridan(s): _____
Home phone number: _____
Cell phone number: _____
Work phone number: _____
Email address: _____

Emergency Contact Information

Name of the emergency contact: _____
Relation to participant: _____
Home phone number: _____
Cell phone number: _____
Work phone number: _____

Medical Information

Health card number: _____
Medical needs – **complete Annex-1**
Allergies/Anaphylaxis – **complete Annex-2**

Do you give us permission to post pictures of your child on our Facebook page?

Yes ☐ No ☐

*Please fill out this part well

Interests:

Strenghts:

Struggles:

Intervention strategies/approaches:

Annex-1

Medical Needs Plan

Child's Full Name: _____

Child's Date of Birth: _____

Date Plan Completed: _____

Medical Conditions:

☐ Diabetes ☐ Asthma ☐ Seizure

☐ Other: _____

PREVENTION & SUPPORT

1. **Steps to reduce the risk of causing or worsening the medical condition(s)**
   Include how to prevent an allergic reaction/other medical emergency; how not to aggravate the medical condition (e.g., pureeing food to minimize choking)

2. **List of medical devices and how to use them**
   Example – feeding tube, stoma, glucose monitor, etc. If not applicable, please indicate "N/A"

3. **Location of medication and/or medical device(s)**
   Example – Glucose monitor is stored in the front pocket of the participant's backpack. If not applicable, please indicate "N/A"

SYMPTOMS AND EMERGENCY ALERTS

1. **Signs and symptoms of all allergic reaction or other medical emergency**
   Include observable physical reactions that indicate the child may need support or assistance (e.g., hives, shortness of breath, bleeding, foaming at the mouth).

2. **Procedure to follow if child has an allergic reaction or other medical emergency**
   Include steps (e.g., Administer 2 puffs of corticosteroids; wait and observe the child's condition; contact emergency services / parent or guardian).

ADDITIONAL INFORMATION RELATED TO THE MEDICAL CONDITION (if applicable)

Parent / Guardian Name (Print)

Relationship to Child

Parent / Guardian Signature

Date

Annex-2

Anaphylaxis Emergency Plan: _____ *(name)*

This person has a potentially life-threatening allergy (anaphylaxis) to:

PHOTO

(Check the appropriate boxes.)

☐ Food(s): _____

_____

_____

☐ Insect stings ☐ Other: _____

Epinephrine Auto-Injector: Expiry Date: _____/_____

Dosage:

☐ EpiPen Jr® 0.15 mg ☐ EpiPen® 0.3 mg

Location of Auto-Injector(s): _____

☐ **Previous anaphylactic reaction:** Person is at greater risk.

☐ **Asthmatic:** Person is at greater risk. If person is having a reaction and has difficulty breathing, give epinephrine auto-injector before asthma medication.

A person having an anaphylactic reaction might have ANY of these signs and symptoms:

- **Skin system:** hives, swelling (face, lips, tongue), itching, warmth, redness
- **Respiratory system (breathing):** coughing, wheezing, shortness of breath, chest pain or tightness, throat tightness, hoarse voice, nasal congestion or hay fever-like symptoms (runny, itchy nose and watery eyes, sneezing), trouble swallowing
- **Gastrointestinal system (stomach):** nausea, pain or cramps, vomiting, diarrhea
- **Cardiovascular system (heart):** paler than normal skin colour/blue colour, weak pulse, passing out, dizziness or lightheadedness, shock
- **Other:** anxiety, sense of doom (the feeling that something bad is about to happen), headache, uterine cramps, metallic taste

Early recognition of symptoms and immediate treatment could save a person's life.

Act quickly. The first signs of a reaction can be mild, but symptoms can get worse very quickly.

1. **Give epinephrine auto-injector** (e.g. EpiPen®) at the first sign of a known or suspected anaphylactic reaction. (See attached instructions.)
2. **Call 9-1-1** or local emergency medical services. Tell them someone is having a life-threatening allergic reaction.
3. **Give a second dose of epinephrine** as early as 5 minutes after the first dose if there is no improvement in symptoms.
4. **Go to the nearest hospital immediately (ideally by ambulance),** even if symptoms are mild or have stopped. The reaction could worsen or come back, even after proper treatment. Stay in the hospital for an appropriate period of observation as decided by the emergency department physician (generally about 4-6 hours).
5. **Call emergency contact person (e.g. parent, guardian).**

Emergency Contact Information

Name	Relationship	Home Phone	Work Phone	Cell Phone

The undersigned patient, parent, or guardian authorizes any adult to administer epinephrine to the above-named person in the event of an anaphylactic reaction, as described above. This protocol has been recommended by the patient's physician.

_____ Patient/Parent/Guardian Signature

_____ Date

_____ Physician Signature ☐ On file

_____ Date