



Camp Massawippi

Recommendation Letter 2011

Camp Massawippi 3161, ch. Round Bay. Ayer's Cliff (Qc) J0B 1C0
Téléphone : 1 866 838-4707; Télécopieur : 819 838-1171

Subject: Referral to *On the Path to an Active Life* Program

You need to get in touch with your healthcare professional to fill out this form and send it to the Camp Massawippi Selection Committee at the address indicated above. Thank you.

INFORMATION ABOUT THE PROSPECTIVE PARTICIPANT

Name : _____	Address : _____
Email : _____	_____
Telephone : _____	Date of birth : _____
School : _____	School year : _____
Regular program <input type="checkbox"/> Special program <input type="checkbox"/>	Languages spoken : English <input type="checkbox"/> French <input type="checkbox"/>
Diagnosis : Spina bifida <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Other <input type="checkbox"/> _____	Mobility : ambulate independently <input type="checkbox"/> walk using equipment <input type="checkbox"/> specify _____ wheelchair : power <input type="checkbox"/> manual <input type="checkbox"/>

In discussion with my client, these are the 3 goals that he/she would like to achieve :

1. _____
2. _____
3. _____

.../next page

I hereby submit the name of my client for participation in the *On the Path to an Active Life* Program that will be held at Camp Massawippi during the summer of 2011.

Even though supervision and assistance are provided at the Camp, I declare that my client is able to:

- participate in group workshops (behaviour, cognitive abilities)
- attend to his/her personal care with minimum assistance
- be away from home/his/her parents for 12 days

My client has begun to participate in household chores, e.g.

He/she also demonstrates an aptitude to:

- live on his/her own in an apartment (supervised or independent)
- hold a job (paid or as a volunteer)
- drive a motor vehicle

I deem my client to be a good prospective participant for the following reasons:

INFORMATION ABOUT THE PROFESSIONAL

NAME OF HEALTHCARE PROFESSIONAL (CAPITAL LETTERS) _____

Title : _____

Name of establishment : _____

Address : _____

Phone : _____

Fax : _____

Email : _____

Signature : _____

NOTE: YOUR PARTICIPATION AFTER THE PROGRAM IS REQUIRED TO ENSURE PROPER FOLLOW-UP OF YOUR CLIENT'S OBJECTIVES. WE THANK YOU FOR YOUR COOPERATION.