20 Belmore St
Penrith NSW 2750
Ph: 4731 3469

www.konfidentkids.com.au

Thank you for your enquiry regarding our Konfident Kids Therapy Camp. Please see attached some information regarding the Camps. If you intend to enroll your child, please see attached the following questionnaires and forms for you to complete to the best of your ability;

- FaHSCIA Consent Form
- Medical Information and Consent Form
- Early Development Questionnaire
- Sensory Profile Checklist

If you have any queries, or would like assistance to complete the questionnaires, please do not hesitate to contact Corinna at our office on (02) 4731 3469

Please return the questionnaires, prior to the start of the Konfident Kids Therapy Camp by one of the following ways:

- **Post** PO Box 1165 Penrith NSW 2751
- **Fax** (02) 4732 3633
- **Email** csceri@accentonhealth.com.au
- **In Person** 20 Belmore St Penrith NSW 2751

Your child's enrolment in the Konfident Kids Therapy Camp will be confirmed by phone / email once the questionnaires and the referral has been received by the office.

To enroll your child into a Konfident Kids Therapy Camp, either log onto our website: www.konfidentkids.com.au or contact our office on 02 4731 3469.

If you have any other queries, please do not hesitate to contact our office.

Yours Sincerely

Geraldine Waters
Psychologist
Paediatric Services Manager

Konfident Kids Therapy Services Information Sheet

The Therapy Camp is aimed at providing intense therapy for children with a diagnosis of Autism Spectrum Disorder (ASD). The camp runs over four days and a collection of multi-disciplinary therapists target fundamental motor, cognitive, communication and social skills that will assist in empowering these children and increase their function within the community. Parents are informed daily on their child's progress. At the conclusion of the camp all the therapists involved in the camp will complete a progress report. The progress report will include homework tasks to assist with generalization and future recommendations.

Location of Therapy Camp:
Konfident Kids Therapy Services Clinic
20 Belmore St Penrith

Glenmore Park Child & Family Precinct
Blue Hills Drive Glenmore Park

Time:
Our staff will provide you with the times of the therapy camps once enrolments have been finalised.

Daily Activities:

- Sensory Integration: Sensory based activities, such as messy play
- Communication: Verbal and non verbal system including visual schedules
- Social skills: Turn Taking and requesting skills
- Play skills: Toy manipulation and interactions
- Motor skills: Fine motor and gross motor
- Cognitive skills: Concepts and positioning
- Following routines: Visual schedules and verbal instruction

Staff:
Occupational Therapists, Speech Pathologists and a Psychologist run the sessions. All staff has extensive experience working with children with an ASD.

Cost:
Our staff will provide you with the cost of the therapy camps once enrolments have been finalised.

What to Wear:

- Comfortable clothing
- Supportive, closed-in shoes only – no sandals or thongs.

What to Bring:

- Morning tea
- All clearly labelled with child's name
- Sufficient Drinks/water

Please note: Konfident Kids is a nut free environment. All food must be nut-free.

Medication:
All medications in tablet/pill form must be packaged in blister packs. Blister packs must state the child's name, type of medication, and dosage. All other medications must be in original containers and labelled with the child's name, medication type, and dosage requirements.

Personal Items:
Please bring a comfort toy if this will assist your child to settle while on camp.

Terms & Conditions

- Parents need to notify the Programme Coordinator of any illnesses, allergies or special needs on the enrolment form
- Please do not bring any products containing nuts to the programme
- Parents need to provide an emergency contact number on the enrolment form
- Parents must notify the Coordinator if someone other than the parent is picking up their child
- Konfident Kids reserves the right to alter the daily activities

For more information or to make a booking visit www.konfidentkids.com.au or phone 4731 3469 – places limited.

Please sign below to confirm your child's attendance at the camp:

Signature: ____

Name;____

Please sign below to indicate approval to claim the cost of the camp to Fahcsia.

Signature: ____

Name;____

Penrith NSW 2750
Ph: 4731 5009

www.konfidentkids.com.au

Konfident Kids Paediatric Therapy Camp Emergency Information

Please complete one form for each child

Child's Name: ______________________________________ DOB: ________________________

Gender (please circle): Male Female

Address: ____

Emergency Contact Person: ____

Relationship to child: ____

Ph (H): ________________________________ (M): ________________________________

(W): __________________________________

Signature: ____

Please indicate any medical condition, allergies, dietary restrictions or history that may effect your child's participation in the Konfident Kids Program. All information is collected, secured and stored in accordance with the Health Records and Information Privacy Act, 2002.

Medical Condition / Special Needs	Comments

Is your child's immunization current and up to date? Yes ☐ No ☐

Child's Doctor: ______________________________________ Phone: _______________________________

Address: ____

Mother's Name:	Father's Name:
Ph (H):	Ph (H):
(W):	(W):
(M):	(M):
Hours of work:	Hours of work:
Signature:	Signature:

Authorised pick-up

1) Name:	2) Name:
Address:	Address
Ph:	Ph:
Relationship to child:	Relationship to child:
Signature:	Signature:

20 Belmore St Penrith
Penrith NSW 2750
Ph: 4731 5009

www.konfidentkids.com.au

Therapy Camp Consent Form

Consent has been given for:

- Konfident Kids staff to seek medical assistance/hospital or other nominated assistance

  Yes No

- Administration of paracetamol after obtaining verbal permission over the phone

  Yes No

- Administration of paracetamol after obtaining permission & advice from medical practitioner

  Yes No

- Child to be transported to hospital by ambulance in emergency

  Yes No

- Administration of sunscreen

  Yes No

- Photographs

  Yes No

Disclaimer

In agreeing to attend Konfident Kids Therapy Programs I:

a) release and forever discharge Accent from all claims that I may have or may have had arising from or in connection with my child and Konfident Kids sessions; and

b) Indemnify, will keep indemnified and hold harmless Accent, to the extent permitted by law in respect of any claim as a result of or in connection with Konfident Kids programs

- I warrant that my child has not at any time suffered blackout, seizure, convulsion, fainting, dizzy spells or any other medical condition and is not presently receiving treatment for any illness, disorder or injury which would render it unsafe for my child to take part in Konfident Kids Programs.
- I have read and I consent for my child to participate in Konfident Kids Programs and understand the risk involved and further agree to be bound by the codes of conduct, rules of Konfident Kids.
- **"Accent"** or **"Konfident Kids"** means all directors personally and in their capacity as a director, partners of directors, agents, and any representatives of both.
- **"Konfident Kids Programs"** include all programs and activities that you or your child participates in during our courses and classes.

Parent/Guardian's Signature:___________________________Date: _________________________

Client Consent Form

Client Consent for Collection of Personal Information

The personal information you are asked to provide is collected to determine your child's eligibility to receive funding under the Helping Children with Autism package. The service provider is required to pass this information to FaHCSIA and/or to another organisation as directed by the Australian Government.

I (name of parent, carer, or guardian)

Of (address)

hereby give consent for the service provider to disclose, as required, my personal information to FaHCSIA or any other organisation directed by the Australian Government. I acknowledge that the disclosure of some or all of my information to the Australian Government will occur for the purpose of assisting the Australian Government to manage its responsibilities.

Parent, Carer or Guardian signature   /   /

Compliance with Information Privacy Principle 2

I (name of Authorised Officer)

Of (outlet name)

(Agreement Schedule ID)

have read and explained to the child's parent, carer or guardian. I believe they understand that:

- the personal information they are asked to provide is collected for the purpose of determining access to and delivery of funding under the Helping Children with Autism Package; and
- this service outlet is required, to pass some or all of this information to FaHCSIA and/or to another organisation as directed by the Australian Government.

Outlet's signature (Authorised officer)   /   /

Client Consent for FaHCSIA

I consent to FaHCSIA contacting me as part of the evaluation of the Helping Children with Autism package.

Please tick ✓ one box.   Yes: ☐   No: ☐

Parent, Carer or Guardian signature   /   /

Australian Government

Department of Families, Housing, Community Services and Indigenous Affairs

Client Consent to Claim Payment Form

By signing this form you are acknowledging that you understand the conditions of funding and that you have authorised a service provider to submit a claim to FaHCSIA on your behalf for an early intervention service you have received.

I (parent, carer, or guardian)	
Of (address)	

hereby authorise the service provider to submit a claim for reimbursement to FaHCSIA with the following details:

Name of Child	
Type of Service	

Parent, Carer, Guardian signature		/ /

Service Provider Declaration

I (name of Authorised Officer)	
Of (outlet name)	
(Agreement Schedule ID)	

have explained to the child's parent, carer, or guardian:

- the conditions under which a claim may be submitted to FaHCSIA on behalf of the child for early intervention funding and their liabilities where no funding remains available for that child; and
- that FaHCSIA will provide a monthly Activity Statement detailing the payments FaHCSIA have made to service providers on behalf of the child. Any discrepancies between the amount authorised to be claimed and the amount that appears on the monthly Activity Statement should be addressed with this service provider/outlet.

Outlet's signature (Authorised officer)		/ /

EARLY DEVELOPMENTAL QUESTIONNAIRE

General Information

Date: ____________________

Child's Name: ____

Address: ____

____

Age: __________________ Sex: M / F Date of Birth: ____________________

School/Preschool: ____

Home Phone: _________________________ Mobile: ________________________________

Mother's Name: _________________ Work Outside Home: ___________________________

Father's Name: __________________ Work Outside Home: ___________________________

Brothers/Sisters: ____

Main Language Spoken at home: ____

Briefly describe your child: ____

____

____

Birth and Toddler History

Were there any illnesses/complications during the pregnancy with this child? _________________

____

Nature of delivery: Full term ☐ Premature ☐ No. Of weeks _____ Caesarean ☐

Were there any complications during labor and/or delivery? Yes ☐ No ☐

Breathing problems ☐ Cord around neck ☐ Colour ☐ Jaundice ☐

Other (please explain) ____

____

Did baby have any complications/problems immediately after birth? __________________________

____

____

Did the baby have colic and/or feeding problems during the first three months? ________________

____

When was s/he weaned and how did s/he respond to this process? ____________________________

____

Milestones

Approximate age:

* Rolled over ____________ * Sat alone ____________ * Stood alone ____________

* Crawled/crept ____________ * Walked ____________ * Pulled to stand ___________

* Babbled ____________ * First words ____________ * Said 2-3 words ___________

* Fed self ____________ * Dressed self ____________

If your child attended day care, at what age? _______________________________________

What type of situation was this (e.g., in home, centre, etc.)? __________________________________

For how many hours a week? ____

Any comments: ____

Current Skills

Tick whether your child can usually complete the following tasks:	**Yes**	**No**
Doing Things at Home		
Follows one part instructions (e.g Take off your shoes.)	☐	☐
Follows two part instructions (e.g. Get your jumper and your hat.)	☐	☐
Able to concentrate on one activity for at least five minutes	☐	☐
Playing		
Understands some concept words (e.g. big/little, short/tall, colour words)	☐	☐
Stacks and assembles blocks or other toys	☐	☐
Shares toys with other children	☐	☐
Takes turns during games	☐	☐
Participates in imaginary play (e.g. pretending to be a mother or a firefighter)	☐	☐
Able to throw a ball	☐	☐
Able to hold a pen or pencil and draw on paper	☐	☐
Looking at Books		
Points to named pictures (e.g. Where's the dog?)	☐	☐
Talking		
Imitate new words heard in conversations	☐	☐
Able to name most everyday objects	☐	☐
Talk in full sentences	☐	☐
Uses grammatically correct sentences	☐	☐

Preschool/Day Care History (if any)

Preschool attended: ____

How many hours per day? __________ Days per week? ____________________

Who is the primary caretaker of the child at home? ____________________________

Any difficulties at preschool? ____

____

____

Strengths at preschool: ____

____

____

Medical History

Has your child had any serious accidents/injuries/illnesses involving such things as:

Convulsions ☐ High fevers ☐ Loss of consciousness ☐ Fainting ☐ Headaches ☐

Chronic fatigue ☐ Head injuries ☐ Ear problems ☐ Meningitis ☐

Other: ____

____

Did your child ever require hospitalisation? If so, please explain: ____________________

____

Current paediatrician's name:____________________ Phone Number:______________

Address: ____

Has your child been given a definitive diagnosis? Yes ☐ No ☐

If yes, what was the diagnosis ? ____

Who was the diagnosis made by? ____

When was the diagnosis made? ____

When was your child's last complete check up? ______________________________

Any allergies?____

Any physical problems?____

____

Any feeding difficulties? ____

____

Is your child currently on medication? If so, please list medication and dosage including frequency:

____

____

Does your child have any health problems at this time? Yes ☐ No ☐

If yes, please list: ____

____

____

____

Any history of:			If yes, approximate age began?
Head banging:	Yes ☐	No ☐	________________
Stuttering:	Yes ☐	No ☐	________________
Breath holding:	Yes ☐	No ☐	________________
Day soiling:	Yes ☐	No ☐	________________
Temper tantrums:	Yes ☐	No ☐	________________
Nail biting:	Yes ☐	No ☐	________________
Excessive Jealousy:	Yes ☐	No ☐	________________
Hitting:	Yes ☐	No ☐	________________
Frequent crying:	Yes ☐	No ☐	________________
Irritability:	Yes ☐	No ☐	________________
Excessive thumb sucking:	Yes ☐	No ☐	________________

	Age Began	Still Occurring?	
Hurting self:	________________	Yes ☐	No ☐
Sleep problems:	________________	Yes ☐	No ☐
Nightmares:	________________	Yes ☐	No ☐
Bedwetting:	________________	Yes ☐	No ☐
Excessive fears:	________________	Yes ☐	No ☐
Excessive fantasizing	________________	Yes ☐	No ☐
Intentionally hurting others:	________________	Yes ☐	No ☐
Problems going to Preschool:	________________	Yes ☐	No ☐
Problems making friends:	________________	Yes ☐	No ☐

How does this child compare with her/his siblings? ____

____

Has your paediatrician identified any concerns about your child's development? Yes ☐ No ☐

If yes, please describe these concerns: ____

____

____

Has your child previously had therapy? Yes ☐ No ☐ If yes, what type? ________________

At what age(s)? __________________ Do you have a report? Yes ☐ No ☐

Therapists Name and contact number: ____

About how many sessions did the child have? _______________________________________

What concerns/progression was made? ____

____

About Your Child

Favourite Toy/Activity: ____

Favourite Food: ____

Favourite Person: ____

Favourite Colour: ____

Fears: ____

What works best when you need to motivate your child to do something difficult? ______________

____

Current Concerns

What are your main concerns about your child? ______________________________________

____

____

What kind of help do you expect from me in working with your child? _______________________

____

____

Any other comments: ____

____

____

____

____

____

____

Name of person(s) completing this form

____

SENSORY PROFILE

Name: ______________________________ DOB: __________________________

Interview with: _________________________On: __________________________

	Always	Often	Sometimes	Seldom	Never
VISUAL					
Has difficulty putting puzzles together					
Hesitates going up or down steps					
Gets lost easily					
Avoids eye contact					
Does not notice when people come into the room					
Becomes overly excited by busy environments					
Covers eyes in bright room					
Avoids bright lights, sunlight					

	Always	Often	Sometimes	Seldom	Never
BODY POSITION/MOVEMENT					
Hangs on other people, furniture, objects etc even in familiar situations					
Seems to have weak muscles					
Tires easily especially when standing or holding a particular body position					
Locks joints for stability					
Walks on toes					
Moves stiffly					
Has a weak grasp					
Can't lift heavy objects					

Props to support self					
Rocks in desk or chair or on floor					
Clumsy					
Avoids or fears movement					
Holds head upright even when leaning over					
Becomes overly excited after movement activity					
Turns whole body to look at you					
Poor endurance, tires easily					
Craves movement					
Prefers fast moving, spinning rides					
Becomes anxious/distressed when feel leave the ground					
Dislikes riding in the car					

	Always	Often	Sometimes	Seldom	Never
TOUCH					
Avoids getting messy					
Expresses distress during grooming					
Is sensitive to certain fabrics					
Avoids being barefoot					
Reacts emotionally or aggressively to touch					
Rubs or scratches out a spot that has been touched					
Gags easily with textured food or utensils in mouth					
Mouths objects frequently					
Decreased awareness of pain and temperature					
Oblivious to touch or mess on hands and face					
Leaves clothes twisted on body					
Isolates self from other children					
Uses poor judgment regarding own space					

Frequently bumps or pushes other children					

	Always	Often	Sometimes	Seldom	Never
AUDITORY					
Responds negatively to unexpected or loud noises					
Holds hands over ears					
Difficulty working with background noise					
Seems oblivious within an active environment					
Makes sounds constantly					

	Always	Often	Sometimes	Seldom	Never
EMOTIONAL/SOCIAL					
Uses inefficient ways of doing things					
Seems to have difficulty liking self					
Is overly affectionate with other children					
Has temper tantrums					
Has nightmares					
Difficulty perceiving body language or facial expressions					

	Always	Often	Sometimes	Seldom	Never
TASTE/SMELL					
Chews/licks non-food items					
Doesn't seem to smell strong odours					
Reacts defensively to smell					

Comments:

____

____

____

____

Therapist: ______________________________

Signed: ________________________________