Kackaamin
FAMILY DEVELOPMENT CENTRE
7830 Beaver Creek Road
Port Alberni, BC V9Y 8N3

Child Intake Application – 5 to 9 Years

Client File Overview:

(This Intake Package is to be completed by the Referral Worker with Parent(s). Please print all responses.)

Date of Application: _____

Last Name: _____ First Name: _____

Male ❑ Female❑ Birthdate: _____/____/_____ Age: _____
YYYY MM DD

Aboriginal Ancestry: Yes ❑ No ❑ On Reserve: Yes ❑ No ❑

Band Name: _____ Status number: _____
Very important to have both*

Personal Health Number: _____

Home Address: _____City: _____

Province: _____ Postal Code: _____Telephone: _____

Full Name of Parents/Guardians: _____

Please note, children must be in parental care/ legally returned by MCFD to attend our program

Emergency Contact: (*Please list a person who may be contacted in case of emergency)*

Name: _____ Relationship: _____

Phone number (cell/home): _____

Immunizations:

Is your child up-to-date on immunizations? Yes ❑ No ❑

If No, is there a medical reason for not immunizing? Please explain:

*******Please note, we require a copy of child's up-to-date immunization records sent in with application and unless medically unable, all children MUST be immunized to attend our program*******

Parent Initials _____

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Are there any physical challenges/ chronic health/ developmental conditions that require special attention? *Please specify:*

If your child has allergies that we need to be aware of, please list them:

******* Please bring epi-pen (plus refills) prescribed by your family physician if required. KFDC does not supply epi-pens for clients or children*******

Client Family Name: _____

Referral Worker Name: _____

Referral Agency: _____

Address: _____

Business #/Cell: _____ **Fax**: _____

Email Address: _____

Parent Initials _____

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Consent to Release Confidential Information

I *(parent)* _____ hereby request and permit KFDC staff to discuss any and all confidential information about my child/ren with my referral worker listed below, and school supports and teachers listed on page 3 of this application on the "Learning Center Information Sheet".

Child Client's Name: _____

Name of Parent: _____

Signature of Parent: _____ Date: _____

Referral Worker's Name: _____

Referral Worker's Signature: _____

Referral Worker Organization/Agency's Name: _____

Address: _____ City: _____

Province: _____ Postal code: _____

Telephone: _____ Fax #: _____

Email address: _____

Alternate contact person within your organization: _____

******* (The alternate contact person is for the confirmation or admission process only – the alternate contact will not be included in the release of confidential information prior to, during, or after treatment. The client may change the name of the person that receives the Discharge Summary at any time. It is up to the client to inform their referral worker of that change.* This form is only applicable for one year after the date it is signed). ******

Parent Initials _____

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Learning Centre Information

The following information is important to the LEARNING CENTRE SCHOOL. ***Please have the child's school program/ teacher complete this section for school aged children.***

Referral Sources and Parents: Please review sheet in its entirety and send with all other intake package forms.

Child's Name: _____ Status #: _____

Address: _____

Parent's Names: _____

Child's Date of Birth: _____

Name of School: _____ School District #: _____

School Address: _____

School Telephone #: _____ School Fax #: _____

Teacher's Name: _____ Child's Current Grade Level: _____

1. Is this child/youth an independent learner?

❑ Never ❑ Sometimes ❑ Often ❑ All the time

Any further comments: _____

_____

2. Please circle if your child has been diagnosed with ADD, ADHD or FASD?

Please describe: _____

_____

3. Is your child currently receiving any extra support services at their school? ❑ Yes ❑ No

If "yes", please describe what type of support services: _____

_____

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4. Is this child receiving counselling through the school? ❑ Yes ❑ No

If so, name and contact information:

_____

_____

5. Please list any additional information that would be helpful to this child's learning plan/ goals while attending Kackaamin Family Development Center:

_____

_____

_____

The KFDC Learning Centre requires 6 (six) weeks of planned work for Elementary students in Math and Language Arts or in two or three core subjects for Secondary students.

At KFDC the children keep a daily journal and have approximately 8 hours each week devoted to academic work. The remaining time is devoted to treatment and healing programming. Topics addressed in healing include: self-esteem, communication, drug and alcohol education, grief and loss, sexual safety and family interactions.

Client Family Name: _____

Referral Worker Name: _____

Referral Agency: _____

Address: _____

Business #/Cell: _____ **Fax**: _____

Email Address: _____

Parent Initials _____