

*Colleague – Rebalance, Renew,
Refresh: Self Care Retreat
July 10 – 14, 2023
Cost: \$100.00*

*Kackaamin Family Development Centre is pleased to
announce an opportunity for front line workers,
helpers and professionals to come together for a week of
rest, relaxation and self-assessment as it relates to:*

*Grief and Loss
Burnout – Compassion Fatigue
Vicarious Trauma
Chronic Stress Injury*

*Healing will be offered to Reinvigorate and Reenergize
through;
Cultural Ceremony
Laughter
Yoga
Creation of a Self Care Plan
And more.....*

We are pleased to be a part of your healing journey.



Returning to the Circle ~ Colleagues

“Returning to the Circle”- July 10 -14, 2023

COST: 100.00

This 5-day program will focus on Health and Wellness as it pertains to the helping field. This program will offer a safe space to begin looking at delayed grief and specific traumas (the roots of addiction) through experiential and cognitive processes using culturally relevant approaches.

Topics for the week include: Compassion Fatigue, Chronic Stress Injury, Vicarious trauma, Tools for wellness
Participants will enjoy some self-care services and positive activities to nurture self and connect with others.

Participants are asked to refrain from any and all drug and alcohol use during programming. Healing will be based on Traditional culture and ceremony- participants’ need to have a clear mind and spirit to connect with the Creator and Ancestors.

All those participating will be sharing their accommodations with others. Kackaamin has 2 bedroom, 3 bedroom, 4 bedroom, 5 bedroom and wheel chair accessible townhouse units. Each unit has one queen bed, and depending on the other units they have twin beds, with bathrooms and full kitchens.

CELL PHONE: We ask that you have your phone off or in your room during program

Kackaamin Family Development Centre Program Guidelines

- No alcohol or drugs onsite. Abstaining a week before is recommended.
- Smoking is allowed in the designated smoking areas
- Participants are responsible for their own travel arrangements to and from the center
- Arrival time on intake day is between 12:00 pm – 4:00 pm

Please connect with Intake Coordinator, Julie Fontaine, at 250-723-7789 or julie.f@kackaamin.org for appropriate applications for summer programming, and for any questions or concerns related to programming application requirements.

PLEASE PRINT CLEARLY

IDENTIFYING INFORMATION

LAST NAME		FIRST NAME		KNOWN AS	
DATE OF BIRTH (YYYY MON DD)		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	TELEPHONE		EMAIL
ADDRESS			CITY	PROVINCE	POSTAL CODE
ABORIGINAL ANCESTRY <input type="checkbox"/> YES <input type="checkbox"/> NO		BAND NAME			ON RESERVE <input type="checkbox"/> YES <input type="checkbox"/> NO
CARE CARD NUMBER			STATUS NUMBER (10 DIGIT NUMBER)		

PERSONAL HISTORY

EMPLOYMENT STATUS <input type="checkbox"/> WORKING <input type="checkbox"/> S.A. <input type="checkbox"/> E.I.C. <input type="checkbox"/> OTHER		MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> COMMON-LAW <input type="checkbox"/> SEPERATED <input type="checkbox"/> DIVORCED	
Are you a survivor of Residential School? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Are you a survivor of a Day School Program? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Are you an Intergenerational Survivor of Residential/ Day School? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Substance Use History- Please Indicate Drugs of Choice and Date of Last Use: (We are collecting this information for program development and client safety while here)			
<input type="checkbox"/> ALCOHOL Date of Last Use:	<input type="checkbox"/> NON- PRESCRIPTION DRUGS Date of Last Use:	<input type="checkbox"/> PRESCRIPTION DRUGS	<input type="checkbox"/> CANNABIS
ii) Abuse Pattern		<input type="checkbox"/> DAILY <input type="checkbox"/> MOSTLY WEEK-ENDS <input type="checkbox"/> BINGE	

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT SURNAME	EMERGENCY CONTACT FIRST NAME	RELATIONSHIP
TELEPHONE	EMAIL	CITY OF RESIDENCE

INFORMATION

Do you have physical limitations that prevent you from doing recreational or cultural activities	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you require a wheel chair accessible unit?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have any allergies (food, insect, medications) we need to be aware of		Please explain	
I understand and accept I will be placed in shared accommodation	<input type="checkbox"/> YES <input type="checkbox"/> NO	I am committed to complete a structured program process focused on my wellness	<input type="checkbox"/> YES <input type="checkbox"/> NO
I am willing to be involved in all types of intensive activities?	<input type="checkbox"/> YES <input type="checkbox"/> NO	I am willing to participate in First Nations Treatment program components such as sweat lodge, daily smudge, pipe and other cultural ceremonies?	<input type="checkbox"/> YES <input type="checkbox"/> NO
I am willing to put aside all external distractions while in the journey to the wellness program	<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you received the COVID-19 Vaccine? 1 st 2 nd 3 rd	<input type="checkbox"/> YES <input type="checkbox"/> NO

TREATMENT NEEDS

Have you engaged in healing programs (healing circle, cultural practice, etc.)?

Specific Treatment

Please note any specific goals or needs (i.e. spiritual, mental, emotional, physical) that you may have during your stay.

Specific Needs

Please note any medical conditions, **allergies or food sensitivities** that we need to be aware of.

HEALTH HISTORY

LAST NAME

FIRST NAME

CARE CARD NUMBER

STATUS NUMBER (10 digit number)

Do you have any medical issues/ conditions?

List all medications you are currently taking, include over-the-counter drugs and herbal supplements

MEDICATION NAME	CURRENT DOSE	TAKING SINE	PATIENT INTIALS	DATE FINISHED

Acknowledgment

I understand I am providing the following confidential medical information for my personal safety while at Kackaamin Family Development Centre, in case of a medical emergency

CLIENT SIGNATUREDATE

REFERRAL WORKER NAMEREFERRAL PHONE:

REFERRAL WORKER SIGNATUREDATE