Super Fun and Pandemonium Groups

Super Saturday /Sunday Group
Referral & Registration

Team Leader: Natalie Talson @ 604-872-4914

Child's Information

Child's Name: ____

Language(s) Spoken: ____

Birthdate: ______________________ Age: ________
Year/Month/day

Currently lives with: ☐ mother ☐ father ☐ other (specify) ________________

Family Doctor's Name: ________________ Phone #: ________________

BC Care Card #: ____

Parent's Information

Caregiver's Name: ____

Address: ____

City: ____________________ Postal Code: ________________

Phone # ☐Home OR ☐Cell ________________ ☐ Texts preferred ☐ Calls preferred

Email address: ______________________☐ Email communication preferred

Relationship to child: ____

Mental Health Team/Referring Source: ________________________________

Referring Worker: ____

Phone number: ______________ email: ________________________

Emergency Contact

The person listed below will be called if there is an emergency, and the caregivers listed above cannot be reached.

Emergency Contact Name: ____

Address: ______________________________________Postal Code: ____________________

Home Phone: _________________ Alternate Phone (work, cell, etc.): ___________________

Language(s) spoken: _____________________Relationship to child: ____________________

Is the above "Emergency Contact" authorized to care for/supervise your child if you are not available?
☐ Yes ☐ No

There may be situations or cases where we would like to share information or contact people who support your child and family outside of our programs. The information that we would share would be about attendance, experience in the group for your child, verbal updates, and progress in the group. If there is anything else specifically that you would like us to share with the professional listed below we will contact you with a separate consent form. The people we may have contact with this information sharing could be teachers, counselors, support workers or referring sources. This is to provide the most consistent care and support for your child and family. Please let us know which professionals are involved with your child and family that you would like us to contact.

Name of Professional	Role	Phone/Email

Is it ok if we share information with the professionals above?

☐ Yes ☐ No (Refusal to consent does not mean refusal of service).

We will review this information sharing list with you each year to make changes as needed.
If you would like to change this list, remove anyone or no longer give consent, please contact us at 604-872-4914.

1. Please briefly describe how having your child attend the Super Fun Group will benefit:

You

____

____

Your child

____

____

2. What are your child's strengths?

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3. What are your child's interests or hobbies?

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4. Please describe all allergies, medications, behavioral, and other relevant medical information for your child that CMHAVF staff should be aware of:

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5. Are there any custody agreements or court orders that CMHAVF staff should be aware of?

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The Super Fun Groups, run by the Canadian Mental Health Association, Vancouver-Fraser Branch (CMHAVF) is a no-fee, recreation program for children whose parent(s) live with a mental health disorder/illness and/or addictions. A maximum group of 12 children (ages 8-12) go on monthly outings to various attractions and activities throughout the Metro Vancouver area. The activities are supervised by two qualified and trained CMHAVF recreation staff along with trained volunteers. Lunches are provided for the children. The recreation staff pick up each child in the CMHAVF van from his/her place of residence on the day of the outing and return the child to the same address at the end of the activity unless other arrangements have been made with staff ahead of time.

Consent

I have read the above description of the CMHAVF Super Fun Group and understand and accept that there are inherent risks associated with the activities. In the event that my child becomes seriously ill or is injured while with CMHAVF and I cannot be reached, I consent to have CMHAVF staff seek any and all hospitalization, medical, dental and/or surgical treatment deemed advisable by the circumstances. While every reasonable precaution is taken with all CMHAVF programs, it is agreed that CMHAVF and its staff and volunteers are released from all liability for injury to my child or for loss or damage to personal property.

Child's Name_______________________________ **Date of Birth**___________________________
Year/month/day

Parent/ Primary Caregiver____
Please print name

Signature of Parent/ Primary Caregiver ____

Witness____
Please print name

Signature of Witness____

Date: __________________________________

Please fax all of the forms to 604-872-5934 attention Natalie Talson

or email natalie.talson@cmha.bc.ca