YOUTH LEAGUE

REGISTRATION FORM

Participant Name:			**Date of Birth:** MM/DD/YYYY
School:			**Gender:**
Parent/Guardian Name:			
Address:			**Primary Ph:**
City:	**Prov:**		**Secondary Ph:**
Postal Code:	**Email:**		

EMERGENCY CONTACT

Name:	**Name:**
Relation:	**Relation:**
Primary Ph:	**Primary Ph:**
Secondary Ph:	**Secondary Ph:**

CODE OF CONDUCT

The safety of each individual in the program is of the utmost importance to Carea Community Health Centre. Each participant has a personal responsibility to learn and follow the safety and other rules established by Carea CHC staff. I hereby agree that any behaviour of the participant that places themselves or others at risk may result in immediate dismissal from the program. Further, if dismissed from the program, I agree to cover any expense(s) arising from such dismissal. In order to ensure the safety and well-being of all individuals participants in the program, Carea Community Health Centre reserves the right to alter the program at any time without notice to the registrant.

☐ I understand and agree Signature:

MEDICAL INFORMATION

Known Medical Conditions	
Allergies	☐ **carries Epi-Pen**
Current Medications	

SEE OTHER SIDE

YOUTH LEAGUE

REGISTRATION FORM

LEAVING THE PROGRAM AND AUTHORIZED PICK-UP

I give permission for my child to leave Youth League and Carea Community Health Centre unattended. If not, please list person(s) that are permitted to pick-up your child below:

☐Yes ☐ No Signature: _____

Name:	**Name:**
Relation:	**Relation:**
Primary Ph:	**Primary Ph:**
Secondary Ph:	**Secondary Ph:**

PHOTOGRAPHY AND VIDEO RELEASE

I give permission for Carea Community Health Centre staff to take photographs of my child during the Youth League program for potential use in future promotional materials.

☐Yes ☐ No Signature: _____

FOOD CONSENT

I give permission for Carea Community Health Centre staff to give my child food and drink as a part of the Youth League program.

☐Yes ☐ No Signature: _____

EMAIL CONSENT

Carea Community Health Centre would like to send you occasional emails regarding Youth League special activities, program interruptions and other announcements via email. I consent to receiving emails from Carea Community Health Centre.

☐Yes ☐ No Signature: _____

If you have any questions or concerns, please contact:

Andy MacGillivray
Community Health Worker
905-723-0036 x2272
Carea Community Health Centre | 115 Grassmere Ave, Oshawa, ON L1H 3X7

Carea Community Health Centre

Carea Community Health Centre
Care. Compassion. Community.

Client Registration Form

Today's date: _____

CLIENT / PARTICIPANT INFORMATION

Last name:		**Birth date:** DD – MM - YYYY
First name:	**Preferred name:**	**Middle Name:**

Sex on Health Card: ☐ Male ☐ Female

Gender Identity: ☐ Male ☐ Two-Spirit ☐ Intersex ☐ Trans- Female to Male ☐ Trans- Male to Female
☐ Female ☐ None ☐ Do not know ☐ Prefer not to answer ☐Other: _____

What is your sexual orientation? ☐ Bi-Sexual ☐ Gay ☐ Heterosexual ☐ Lesbian ☐ Queer
☐ Two-Spirit ☐Other: _____ ☐ Do not know ☐ Prefer not to answer

Address:			**No Fixed Address:** □ Living in Shelter □ Living on the street □ Other (i.e. Home of friend)
City:	**Province:**	**Postal Code:**	

Home Phone:	**Work phone:**	**Cell phone:**

Preferred Language: ☐ English ☐ French ☐ Other (Please Specify):

Allergies:

HEALTH CARD INFORMATION

Health Card #:	**Version Code:**
Exact Name on Health Card:	**Expiry Date:** DD – MM - YYYY

If you do not have a health card, why?
□ OHIP Eligible but no card (Lost Health Card)
□ No Insurance
□ Other Province (Name): _____
□ Interim Federal Health Program: # _____
□ 3 month wait period

REMINDER CALLS

Carea Community Health Centre may use an automated call system to remind you of appointments. The system will try contacting you within 24 to 48 hours of your booked appointment(s).
Do you consent to Carea calling or texting you by our reminder system? ☐ YES ☐ NO
How would you like to be notified? ☐ HOME ☐ WORK ☐ CELL ☐ TEXT

DEMOGRAPHIC INFORMATION

The Ministry of Health requires that we collect additional information about the clients we serve for its provincial wide evaluation project. Please fill in the following to the best of your ability. **This information should focus on the registered participant.**

What is your racial or ethnic group:

☐ Asian – East
☐ Asian – South
☐ Asian – South East
☐ Black – African
☐ Black – Caribbean
☐ Black – North American
☐ First Nations
☐ Indian – Caribbean
☐ Indigenous / Aboriginal
☐ Inuit
☐ Latin American
☐ Metis
☐ Middle Eastern
☐ White – European
☐ White – North American
☐ Mixed Heritage (Please Specify) _____
☐ Other (Please Specify) _____
☐ Do not know
☐ Do not wish to answer

Country of Birth:	**Arrival Date in Canada:** DD – MM – YYYY

What is your religion?

☐ Anglican
☐ Buddhist
☐ Catholic
☐ Christian
☐ Hindu
☐ Jewish
☐ Jehovah's Witness
☐ Muslim
☐ Protestant
☐ Sikh
☐ None
☐ Other (please specify) _____
☐ Prefer not to answer

DEMOGRAPHIC INFORMATION CONTINUED

Please indicate the highest level of education	Combined annual household income	Household composition
☐Too young for primary completion ☐ Primary (Grades 1 to 8) ☐ Secondary (Grades 9 to 12) ☐Post-Secondary or equivalent ☐ No formal education ☐ Other: _____ ☐ Do not know ☐ Prefer not to answer	☐$0 - $14,999 ☐ $15,000 - $19,999 ☐ $20,000 - $24,999 ☐ $25,000 - $29,999 ☐ $30,000 - $34,999 ☐ $35,000 - $39,999 ☐ $40,000 - $59,999 ☐ $60,000 + ☐ Prefer not to answer How many people are supported by this income? _____	☐ Mother, father, child(ren) ☐ Couple without child(ren) ☐ Sole member ☐ Single parent family (father) ☐ Single parent family (mother) ☐ Grandparents with grandchild(ren) ☐ Siblings ☐ Same-sex couple with/without children ☐ Unrelated housemates ☐ Extended family ☐ Other: _____ ☐ Prefer not to answer

Do you have any of the following? Check ALL that apply:

☐ Chronic Illness (Diabetes, Heart Disease, etc.)
☐ Developmental Disability
☐ Drug or Alcohol Dependence
☐ Learning Disability
☐ Mental Illness
☐ Physical Disability
☐ Sensory Disability
☐ Other (please specify)

_____

☐ None
☐ Do not know
☐ Prefer not to answer

CHILD'S LEGAL GUARDIAN (IF APPLICABLE)

Name:	**Relationship to client:**	
Address: ☐ Same as Above	**Home Phone:**	**Alternate Phone:**

Name:	**Relationship to client:**	
Address: ☐ Same as Above	**Home Phone:**	**Alternate Phone:**

EMERGENCY CONTACT INFORMATION

Name:	**Relationship to client:**
Home Phone #:	**Alternate Phone #:**

PRIVACY POLICY STATEMENT

We encourage you to review Carea Community Health Centre's Privacy Policy. Please read the following information regarding our privacy practices. Your privacy is very important to us at Carea Community Health Centre. The personal health information that you give us will be held and may be used and shared to make sure we are able to provide you with the best possible care.

Your personal health information will not be released to any person outside Carea Community Health Centre without your written or verbal consent, except under the following conditions:

- Where an individual appears to be a danger to themselves and others
- Where child abuse is suspected
- Where we are required by law, statute or regulation

You have the right to withdraw your consent or to limit the information that you give us. However, this may result in a change in the care that we provide.

I have read and understand the above privacy policy information.

Printed Name: _____ Signature: _____ _____ Date:_____

If you have any questions about Carea Community Health Centre's Privacy Policy please contact our Privacy Officer at 905-723-0036

Office Use Only:

Date Received: Staff entered by: Chart #: