Carea Community Health Centre
Care. Compassion. Community.

☐ Medical / Counseling Client
☐ HEP C Client
☐ DEP Client
☒ HPCDS Program: VIK Summer Camp

Client Registration Form

Today's date: _____

CLIENT / PARTICIPANT INFORMATION

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

Gender on Birth Certificate: ☐ Male ☐ Female

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

Primary Phone #:	**Alternate Phone #:**

Email Address:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Common Law
☐ Separated ☐ Other (Please Specify): _____ ☐ Unknown

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

Allergies:

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

Citizenship: ☐ Canadian ☐ Landed Immigrant ☐ Refugee ☐ Indigenous ☐ Refugee Claimant
☐ Government Assisted Refugee ☐ Private Sponsored Refugee ☐ Other

Country of Birth:	**Arrival Date in Canada (if applicable):** n/a DD – MM – YYYY

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 on your primary phone by our reminder system? ☐ YES ☒ NO

HOW DID YOU HEAR ABOUT CAREA COMMUNITY HEALTH CENTRE?

☐ Referral: _____ ☐ Website ☐ Social Media ☐ Newspaper ☐ Other (Please Specify): _____

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

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 (University / College) ☐ 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

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

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

PARENT / GUARDIAN CONTACT INFORMATION (IF UNDER CLIENT UNDER 16)

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

EMERGENCY CONTACT INFORMATION

Name:	Relationship to client:	
Address: ☐ Same as Above	Primary 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 #:

Carea Youth
VIK Summer Camp

Registration Form

Participant Information

Participant Name:	Date of Birth: MM/DD/YYYY
School:	Gender:

Main Contact

Name:		Relation:
Address:		Primary Ph:
City:	Prov:	Secondary Ph:
Postal Code:	Email:	

Emergency Contact 1

☐ Authorized to pick up participant

Name:		Relation:
Address:		Primary Ph:
City:	Prov:	Secondary Ph:
Postal Code:	Email:	

Emergency Contact 2

☐ Authorized to pick up participant

Name:		Relation:
Address:		Primary Ph:
City:	Prov:	Secondary Ph:
Postal Code:	Email:	

Participant Health Information

Known Medical Conditions	
Allergies	☐ carries Epi-Pen
Current Medications	
Health Card No.	Expiry Date
Does the participant require 1:1 support for this program? ☐ Yes ☐ No	
Dietary restrictions: ☐ Halal ☐ Vegetarian ☐ Gluten-Free ☐ Lactose Intolerant ☐ Other: _____	

Carea Youth
VIK Summer Camp

Registration Form

Program Registration

Please indicate the program weeks, extended care options, and hotdog lunch options you would like to register for:

VIK Summer Camp — 9:00am drop-off / 4:00pm pick-up

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
Program Week	☐ $65	☐ $75	☐ $75	☐ $75	☐ $75	☐ $65	☐ $75	☐ $75

Extended Care — 8:00am drop-off / 5:00pm pick-up

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
Program Week	☐ $15	☐ $15	☐ $15	☐ $15	☐ $15	☐ $15	☐ $15	☐ $15

Hotdog Lunch — Fridays

	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
All Beef (Quantity)	$2 each	$2 each	$2 each	$2 each	$2 each	$2 each	$2 each	$2 each
Veggie (Quanitity)	$2 each	$2 each	$2 each	$2 each	$2 each	$2 each	$2 each	$2 each

Total Amount: $ _____

Leaving the Program and Authorized Pick-up

Carea Community Health Centre requires that you identify those authorized to pick up the participant from the program aside from the main contact. Emergency Contacts on Page 1 can be identified as authorized by checking the "Authorized to pick up participant" box in the emergency contact section of this form. Only those with authorization on this form will be permitted to pick up the participant. Those authorized to pick up the participant will be required to present government issued photo ID upon pickup. If there are circumstances that you need to make changes to those authorized to pick up the participant, you may contact us at 905-723-0036 and make arrangements with the Camp Coordinator.

☑ I understand and agree

Signature: _____

Other Authorized Individuals for Participant Pickup (aside from Page 1)

Name:	**Phone:**
Name:	**Phone:**

Carea Youth
VIK Summer Camp

Registration Form

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 Emergencies

In the event of an accident, injury, or illness involving the participant, and immediate contact by Carea Community Health Centre with the emergency contacts cannot be made, I hereby authorize and grant persmission for Carea Community Health Centre staff to secure proper medical treatment, and authorize on the participant's behalf all procedures including xrays, tests or treatment, injections, anesthesia and/or surgery, as deemed necessary by the attending medical professional(s). I agree not to hold Carea Community Health Centre responsible for any costs or injury arising from an emergency situation.

☑ I understand and agree **Signature:** _____

Media Release

I give permission for Carea Community Health Centre staff to take capture media of my child during the program for potential use in future promotional resources and reports for the agency.

☑ Yes ☐ No **Signature:** _____

Food Consent

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

☑ Yes ☐ No **Signature:** _____

Email Consent

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

☑ Yes ☐ No **Signature:** _____

Amilia® Privacy Statement

Carea Community Health Centre uses a third-party registration platform known as Amilia® for administering the VIK Summer Camp program. For more information regarding their privacy policy please visit www.amilia.com/legal/privacy
I consent to allowing Carea Community Health Centre to enter the provided information on this form into the Amilia® platform for administrative use in the VIK Summer Camp program.

☑ Yes ☐ No **Signature:** _____