Canadian Mental Health Association
Vancouver-Fraser
Mental health for all

Association canadienne pour la santé mentale
Vancouver-Fraser
La santé mentale pour tous

UROK Urban Resilience Opportunities for Kids

Children and Youth Recreation

UROK program ☐ OR Pandemonium program ☐

Participant's Information

Participant's Name: _____Preferred Gender Pronoun: _____

Cultural Background/Language(s): _____

Birthdate: _____ Age: _____Currently lives with: _____
Year/Month/day

Family Doctor's Name: _____ Doctor Phone #: _____

BC Care Card #: _____

Primary Caregiver Information

Caregiver's Name: _____

Address: _____ Postal Code: _____

Phone # ☐Home OR ☐Cell _____☐ Prefer Texts ☐Prefer Calls

Relationship to child: _____

Caregiver Email: _____ Phone number: _____

Mental Health Team/Referring Source: _____

Referring Worker: _____

Vancouver Office: 110 - 2425 Quebec Street, Vancouver, BC V5T 4L6 Tel: 604-872-4902 Fax: 604-872-5934
New West Office: 435 Sixth Street, New Westminster, BC V3L 3B1 Tel: 604-516-8080 Fax: 604-524-2870
Delta Office: 4871 Delta Street, Delta, BC V4K 2T9 Tel: 604-943-1878
vf.cmha.bc.ca

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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: _____

Primary phone: _____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 604-880-9749.

1. Please briefly describe how having your child attend UROK will benefit:

You_____

_____

Your child

_____

_____

2. What are your child's strengths?

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

6. We get emails with resources for workshops and events that pertain to child & youth mental health or for parenting support, resources for low income families etc. Would you like us to forward you such emails? If yes, anything specific?

_____

_____

Consent

The UROK program, run by the Canadian Mental Health Association, Vancouver-Fraser Branch (CMHAVF) is a no-fee, recreation program. UROK weekend groups are for children whose parent has a mental health concern. UROK Pandemonium is for youth experiencing a mental health concern. A maximum group of 13 children (ages 8-12 & 13-17) 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.

I have read the above description of the CMHAVF 'UROK' program 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 Arietha Jack or email arietha.jack@cmhavf.ca