Centre Famille et Ressource
Bâtir le Succès de la Communauté, Une Famille à la Fois

Family Resource Center
Building Community Success One Family At A Time

Program Registration Form

CONTACT INFORMATION

Name of Client _____

Address _____

_____

Home Phone _____

Cell Phone _____ Work Phone _____

Other Phone _____

Email Address _____

PROGRAM OF INTEREST

Please state the program of interest:

_____

CLIENT INFORMATION

Date of Birth _____

Age _____

Medicare Number _____ Expires: _____

Doctor's Name & Number _____

Occupation _____

4855A Blvd. Des Sources, Pierrefonds, Québec H8Y 3C8
Tel. 514-685-5912 | Fax. 514-685-5914
info@familyresourcecenter.qc.ca | www.familyresourcecenter.qc.ca

LinkedIn

For students only

Name of School:

Grade:

Have you been diagnosed with a learning disability or other mental health condition?
If yes, please specify:

Date of Assessment:

Assessed by:

REFERRAL

Who referred you to the Center?

CLIENT QUESTIONNAIRE

1. What brought you to the Family Resource Center?

2. Which of these reasons is the most problematic?

3. How often and where does it occur?

4. Do you have a support group? Or people that you can go to for help and support? If so who and for what, describe the relationship.

5. Have you previously sought help for this issue?

   If yes, when and with who?
   If no, go to question 7

6. What interventions were administered?

7. What has worked/ helped and what hasn't?

8. What makes you want to seek help now?

9. What do you expect to gain from our programs? What would be a reasonable goal for you?

10. Is there any further information you feel would be pertinent?

11. How did you hear about us?

_____ _____

Client Signature Date

Adult Medical Consent Form

I, _____, authorize the staff at the Family Resource Center to administer any form of First Aid in the event of an emergency or injury. I understand that if needed, steps will be taken to notify the appropriate healthcare professionals, and that the center will make any necessary medical decisions until I can consent or my emergency contact can be reached.

EMERGENCY CONTACT

Emergency Contact: _____

Relationship: _____ Phone number: _____

MEDICAL INFORMATION

Medicare number: _____

Medical Conditions:

_____

_____

Allergies:

_____

_____

Epipen: _____ Medical Alert bracelet: _____ Other: _____

Medications:

_____

Signature of individual: _____

Phone number: _____ Date: _____

Authorization for Pictures/Videos

I, _____ , (legal guardian of

_____, child under 18), give permission to have myself/child photographed or video taped. I understand that this footage may be used for promotional purposes outside of the organization

Exceptions:

_____

_____

_____

Comments:

_____

_____

_____

_____

Signature of Guardian

_____

Date