



NNADAP/YSAC Family Intake & Referral Application

Primary Participant

PLEASE NOTE: ALL SECTIONS MUST BE COMPLETED. INCOMPLETE APPLICATIONS MAY BE RETURNED, DELAYING THE PROCESS. Form to be completed by referring agent.

If any information is not applicable, indicate as NA, unknown as UNK and unavailable as UNA. Attach a separate sheet of paper if more room is needed.

Date of Application: (MM/DD/YYYY) _____

Date Application Received by Treatment Centre: (MM/DD/YYYY) _____

Name of the referral worker/agency: _____

Phone number: _____

Program start date(s) participant is willing to enter treatment on (MM/DD/YYYY):

If the participant is flexible and willing to enter treatment at any of multiple program start dates, please list all viable dates, however, participant will only be permitted to attend one session.

Your participant is applying to the program as:

- Single mom with children
- Single dad with children
- Couple with children
- Couple with no children
- Extended family with children

A. Client Information

Surname:

Language Understood:

First Name:

Status Indian:

Nickname/other name known by:

Treaty Number:

Date of Birth:

Band Name:

Age:

Other Indigenous Status:

Sex:

Relationship Status:

Health Card Number:

Emergency Contact:

Health Card Expiry Date:

Next of Kin:

Client Address:

Relationship to Next of Kin:

Client Phone:

Phone number of Next of Kin:

Language Spoken:

Language Preferred:

Income Source:

- Assistance (Social Assistance or Government)
- Disability
- Employment Income/Occupation
- Employment Insurance (EI)
- None
- Other

Employment Status:

- | | | |
|--|--|---|
| <input type="checkbox"/> Self-Employed. | <input type="checkbox"/> Full time Employment | <input type="checkbox"/> Part Time Employment |
| <input type="checkbox"/> Full Time Seasonal | <input type="checkbox"/> Part Time Seasonal | <input type="checkbox"/> Full Time Student |
| <input type="checkbox"/> Part Time Student | <input type="checkbox"/> Unemployed | <input type="checkbox"/> Social Assistance |
| <input type="checkbox"/> Disability Assistance | <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Volunteer |
| <input type="checkbox"/> Retired | <input type="checkbox"/> Student | <input type="checkbox"/> Training |
| <input type="checkbox"/> Homemaker | <input type="checkbox"/> Other | |

Is this family receiving any additional supports from Jordan's Principle Programs?

If yes, please describe: _____

B. Legal Status

Has your client ever been in trouble with the law? Yes No

If yes, please explain: _____

Is your client under any of these legal involvements?

- Criminal Court Family Court Drug Court Treatment Probation
 Charges Pending Court Referral Court Order Unknown
 Restorative Justice No Involvement

Gang Involvement: Yes No

Is your client involved in any of the following legal conditions?

- Bail Parole Temporary Absence No Involvement

If other, please specify: _____

Was alcohol or any other substances; such as 'sniff' or other drugs involved in your client's legal dealing?

- Yes No Unknown Other

If other, please specify: _____

Is your client seeking treatment as a result of a court order or family service order?

- Yes No Unknown

If yes, please explain: _____

C. Children

Other children and their child welfare status (**Not attending treatment immediately**)

Name	Date of Birth	Provincial Health Number	Status	Sex	Custody Information
				<input type="checkbox"/> Female <input type="checkbox"/> Male Other: _____	<input type="checkbox"/> Customary Traditional <input type="checkbox"/> Adoption <input type="checkbox"/> Biological <input type="checkbox"/> Kinship/Foster <input type="checkbox"/> Recent Apprehension <input type="checkbox"/> Voluntary Family Services <input type="checkbox"/> Orders of Supervision <input type="checkbox"/> Unsupervised Visitation <input type="checkbox"/> Continued Supervision <input type="checkbox"/> Temporary Supervision <input type="checkbox"/> Voluntary Placement Agreement <input type="checkbox"/> Continuous Care (Ongoing Family Services)
				<input type="checkbox"/> Female <input type="checkbox"/> Male Other: _____	<input type="checkbox"/> Customary Traditional <input type="checkbox"/> Adoption <input type="checkbox"/> Biological <input type="checkbox"/> Kinship/Foster <input type="checkbox"/> Recent Apprehension <input type="checkbox"/> Voluntary Family Services <input type="checkbox"/> Orders of Supervision <input type="checkbox"/> Unsupervised Visitation <input type="checkbox"/> Continued Supervision

					<input type="checkbox"/> Temporary Supervision <input type="checkbox"/> Voluntary Placement Agreement <input type="checkbox"/> Continuous Care (Ongoing Family Services)
				<input type="checkbox"/> Female <input type="checkbox"/> Male Other: _____	<input type="checkbox"/> Customary Traditional <input type="checkbox"/> Adoption <input type="checkbox"/> Biological <input type="checkbox"/> Kinship/Foster <input type="checkbox"/> Recent Apprehension <input type="checkbox"/> Voluntary Family Services <input type="checkbox"/> Orders of Supervision <input type="checkbox"/> Unsupervised Visitation <input type="checkbox"/> Continued Supervision <input type="checkbox"/> Temporary Supervision <input type="checkbox"/> Voluntary Placement Agreement <input type="checkbox"/> Continuous Care (Ongoing Family Services)
				<input type="checkbox"/> Female <input type="checkbox"/> Male Other: _____	<input type="checkbox"/> Customary Traditional <input type="checkbox"/> Adoption <input type="checkbox"/> Biological <input type="checkbox"/> Kinship/Foster <input type="checkbox"/> Recent Apprehension <input type="checkbox"/> Voluntary Family Services <input type="checkbox"/> Orders of Supervision <input type="checkbox"/> Unsupervised Visitation <input type="checkbox"/> Continued Supervision

					<input type="checkbox"/> Temporary Supervision <input type="checkbox"/> Voluntary Placement Agreement <input type="checkbox"/> Continuous Care (Ongoing Family Services)
--	--	--	--	--	--

Children's education and social status: (Not attending treatment immediately)

Child	Grade Level	Has an Individual Education Plan	Has an Academic Assessment	Has Received Guidance Counselling	Has been previously apprehended	Has received a Behavior Assessment
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

D. Chemical Use History - Substance misuse prior to treatment history:

At what age did your client start sniffing? _____ At what age did your client start drinking? _____

At what age did your client start using other drugs? _____

Does anyone else in their family use solvents/substances? _____

If yes, please specify: _____

Has anyone in their family or community received treatment for solvent/substance abuse?

Yes No Unknown

If yes, please explain: _____

Has the client participated in a non-residential/community-based substance abuse program?

Yes No Unknown

If yes, please explain: _____

Has your client received prior treatment at a residential addiction centre?

Yes No Unknown

If yes, please explain: _____

Treatment Location	Treatment Date	Describe

Substance misuse for last year: _____

Has your client used substances for the last year? _____

If yes, complete a DUSI-R Assessment

E. Pre-Treatment

Has the client attended a pre-treatment counselling session with you?

Yes No Unknown

If yes, please explain: _____

Has the client attended any withdrawal management prior to coming to the treatment centre?

Yes No Unknown

If yes, please explain: _____

F. Withdrawal Symptoms

Has your client experienced any of the following symptoms while withdrawing from substances in the last 6 months?

Symptoms	Describe
Blackouts <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Hallucinations <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Nausea/Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Shakes <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Delirium Tremens (DTs) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Ever experienced DTs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

G. Mental Health History

Provide the following information about the client's mental health status:

<i>Mental Illness</i>	<i>Describe</i>
<p><i>Been diagnosed with a mental illness</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Currently being treated</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Currently on psychiatric medication</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Taking medication consistently</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Has your client ever spoken or written about killing themselves?</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Previous suicide attempts/ideations? If yes, please explain how and when:</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Hospitalized for suicide attempts? If yes, when?</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Currently suicidal?</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p><i>Has your client received prior treatment from mental health services? If yes, indicate below:</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	
<p>Treatment Location: Treatment Date:</p>	
<p><i>If any treatment program was NOT completed, please provide details:</i></p>	

Has your primary participant participated in other programs/services ie. relationship counselling, anger management or depression?

Yes No Unknown

If yes, when and describe: _____

Year	Treatment Center	Type of Addiction	Completed	Comments
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Reasons for currently requesting treatment (please comment on motivation and participant strength):

H. Social Functioning

Is there any known history of sexual abuse? Yes No Unknown

Is there any known history of physical abuse? Yes No Unknown

Is there any history of family violence that the client may have been witness to?

Yes No Unknown

Any self-harming behaviour(s)? Yes No Unknown

Please indicate which (if any) of the following issues have been a part of your client's family life and provide pertinent details in the associated space.

- Physically aggressive, abusive, or threatening behaviors Sexually aggressive behaviors or promiscuity (verbal or physical)
- Verbally aggressive abusive, or threatening behaviors Uncontrollable outbursts of anger
- Depression Suicidal ideation
- Suicidal attempts Self-harm or mutilation

Please specify details and dates:

- Running away Recklessness/unhealthy risk taking
- Severe and debilitating anxiety Co-dependent/controlling
- Eating disorder ADHD (Attention Deficit Hyperactivity Disorder)

Please specify details and dates:

- FAS/FAE (Fetal Alcohol Syndrome/Fetal Alcohol Effects) Mental Disorder
- Intellectual Development Disability Difficulty following rules or regulations
- Dislike of or disregard for the authority figures Substance withdrawal (detoxification)
- Medical complications that may affect treatment Other destructive behaviors (ie. vandalism, arson)

Does your client go to school?

- Yes No

Child Welfare Involvement?

- Yes No Unknown

I. Historical Trauma Event

Has your client experienced historical trauma? Yes No Unknown

What kind of historical trauma has your client experienced?

- Attended residential school
- Experienced trauma in residential school
- Experiences physical abuse (not residential school)
- Experienced emotional abuse (not residential school)
- Experienced sexual abuse (not residential school)
- Experienced trauma in foster care
- Experienced multiple foster care placements
- Was separated from parents/family for other reasons
- A family member/friend attempted suicide in the past year
- Experienced natural death of a family/friend in the past year
- Experienced death of a family member/friend in the past year
- Experienced multiple deaths in my community in the past year
- Experienced disaster/crisis in my community in the past year
- Parent(s) attended residential school
- Grandparent(s) attended residential school
- Child abuse
- Intergenerational trauma
- Relocation
- PTSD
- Sixties Scoop Survivor
- Foster Placement
- Other, please specify: _____

J. Client's Stage of Readiness

- Pre-contemplation – Not considering change, resistant to change
- Contemplation – Unsure of whether to change, chronic indecision
- Determination – Preparation; committed to changing behaviour within one month
- Action – Begin behaviour change
- Maintenance – Behaviour change has persisted for 6 months or more

Please list any questions or concerns the client has indicated during the intake process:

Charles J. Andrew Youth and Family Treatment Centre

Motivational Interviewing Questionnaire

1. Did anything happen that made you feel that you have to go to treatment? If yes, what happened?

2. Do you see yourself completing the full program?

3. Have you made arrangements to complete the full program with work, school, etc?

4. Are there any medical issues that may interfere with your treatment program?

5. Do you have any upcoming court dates?

6. What are your goals in life? Do you want to work full time?

Do you want to have a happy relationship with your
spouse/children/family?

7. What would you like to work on during your treatment program?

8. Do you have others that can help you or listen to you?



CHARLES J. ANDREW YOUTH and FAMILY TREATMENT CENTRE

PO Box 109

Sheshatshiu, Labrador A0P 1M0

Telephone: 709-497-8995

Fax: 709-497-8993

CONSENT TO MEDICAL TREATMENT

I, _____, hereby give permission for myself and my
child(ren) _____,

To allow a physician selected by Charles J. Andrew Youth and Family Treatment Centre to hospitalize
and/or procure medical treatment for myself, and my child(ren), as listed above, in case of a serious
accident or medical emergency and I am unable to make the necessary decision(s).

Band/Beneficiary Number: _____

Health Care Numbers & Province: _____

Signature of Client: _____ Date: _____

Signature of CJAY staff: _____ Date: _____



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EDUCATION CONSENT

I, _____, do hereby give consent to the Charles J. Andrew Youth
Parent/Guardian and Family Treatment Centre.

And Family Treatment Centre to provide minimum educational programming for

Youth/Child(ren)

Date of Birth(s)

I also give permission to release my child's school student records to be quickly returned to home/school upon completion of treatment.

Parent/Guardian Signature

Youth Signature

Parent/Guardian Name

Youth Name

Date

Date



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AUTHORIZATION FOR RELEASE OF INFORMATION

- 1.** I hereby authorize the Charles J. Andrew Youth and Family Treatment Centre to receive from and/or release information to any person or agency (such as physician, hospital, vocational and other agencies) with due safeguard or confidentiality, on my behalf.

Date: _____

Signed: _____

Witness: _____

- 2.** I do not wish any information, abstracts or any indication of any manner about myself or my stay here to be released to any person or agency, unless I give specific written notice to the Charles J. Andrew Youth and Family Treatment Centre to indicate authorization for release.

Date: _____

Signed: _____

Witness: _____



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LIABILITY WAIVER

I _____ give permission for myself and my child(ren),

to take part in various community, sporting, cultural and educational activities while attending the healing program at Charles J. Andrew Youth and Family Treatment Centre.

I understand that although my child will be under adult supervision during all activities, accidents and injuries are still possible and sometimes inevitable.

I hereby absolve the Treatment Centre and its staff from any liability should an accidental injury occur to myself and my child(ren) during their stay at CJAY; including possible accident/injury during vehicle transportation to and from program outings.

Signature of Client

Date

Signature of Witness

Date



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RELEASE AND WAIVER FOR NUTSHIMIT PROGRAM PARTICIPANTS

Adults Full Name: _____ Date: ____/____/____
Date of birth ____/____/____, Date of birth ____/____/____, Date of birth ____/____/____
Child(ren) full name: _____ Date of birth ____/____/____
Address: _____

I UNDERSTAND that the Nutshimit Program is to provide myself and my child(ren) with the opportunity to participate in a healing process; and to provide myself with instruction in a traditional cultural lifestyle (such as hunting, fishing, gathering, and trapping) while away from the distractions and difficulties of life in the community, with the hope that any previous difficulties will be overcome.

MY DECISION TO PARTICIPATE in the Nutshimit Program while at the Charles J Andrew Youth and Family Treatment Centre is of my own choosing and that of my family. I am mindful of the importance of safety and I am aware of all aspects of safety, including and during outdoor and indoor programming. I have had the opportunity to review the policies and procedures of the Nutshimit Program provided by CJAY.

I ALSO UNDERSTAND that the program will involve the use and teaching of traditional lifestyles and skills (including counseling, preparation of food, gathering, trapping, and hunting) and that I may use and/or have access to, and/or operate, equipment such as boats, snowmobiles, chainsaws, knives, harpoons, and firearms, and/or other equipment and/or be in the vicinity where firearms and/or other equipment are being used, discharged and stored. I SHALL, at all times during my participation in the program, use and take such measures to ensure the safety of myself, my family and the other participants and staff of the Charles J. Andrew Youth and Family Treatment Centre.

IN CONSIDERATION of the CHARLES J ANDREW YOUTH and FAMILY TREATMENT CENTRE accepting me to be a participant of the Nutshimit Program, I _____, my heirs, and executors, RELEASE the CHARLES J ANDREW YOUTH and FAMILY TREATMENT CENTRE and its respective servants, agents, or employees from any and all claims, demands, actions or causes of actions arising out of or in consequences of any loss, injury or damage to my person or property or to any family members or relations that may be attending the said program with me incurred while attending or participating in the Nutshimit Program, notwithstanding any such loss, injury or damage may have arisen by reason of the negligence of the CHARLES J ANDREW YOUTH and FAMILY TREATMENT CENTRE, its respective servants, agents, or employees.

Participants Signature

Clients Signature

Witness



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PHOTOGRAPH RELEASE

From time-to-time CJAY will use un-identifying client photos in annual reports, conference summaries, reports, brochures, advertisements, newsletters, website and power point presentations. CJAY strives to uphold the strictest confidentiality about its clients and their families; therefore, we do not use full face photos of clients and strive to only use photos which do not identify the client.

PERMISSION GIVEN

I _____ hereby give permission for CJAY to use photographs of
Client's Name

_____ (which will not show my own or my child's face or identifies
Client/Youth Name

them in anyway) in promotional material, on its website, in its newsletter, annual reports, conference summaries, reports, and power point presentations.

PERMISSION DENIED

I _____ do not give permission for CJAY to use any photographs of
Client's Name

_____ (which will not show my child's face or identifies them in any way)
Client/Youth Name

in promotional material, on its website, in its newsletter, annual reports, conference summaries, reports, and power point presentations.



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Data Base (AMIS) Consent Form

I _____ give consent for my information and my family members
(name of client)
information to be entered into the CJAY data base (AMIS). I also consent that this information be
shared with other treatment centres and treatment centre staff when applicable or necessary.

(name of family member)

(name of family member)

(name of family member)

(name of family member)

(name of family member)

(name of family member)

(Clients Signature)

(Date)

(Witness Signature)

(Date)



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COMMITMENT TO CARE

Preamble:

Charles J. Andrew Youth & Family Treatment Centre is a ten (10) bed facility, seeking to provide cultural and therapeutic treatment to youth and families who are expressing a need to change. It is important to remember that life events that brought the family to the point of needing residential treatment are varied and it is therefore appropriate to understand that the treatment length of eight (8) weeks is necessary for a successful treatment process.

Charles J. Andrew Youth and Family Treatment Centre recognizes and encourages you, the family members and the referring/support worker to work together on a treatment plan.

This form is a statement of what you are willing to do:

Family:

1. What are your goals for attending treatment?

2. Are you willing to revisit these goals at the halfway point?

_____yes _____no

Worker:

1. Will you call to check on the progress of your client? _____yes _____no
2. Are you planning on visiting our client during treatment? _____yes _____no
3. Are you willing to revisit these goals at the halfway point? _____yes _____no



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COMMITMENT TO CARE

Is there anyone WE SHOULD NOT CONTACT while the youth and family are in treatment?

_____yes _____no

If so, what are the names?

We commit to the plans stated on page 1 of the Commitment to Care form:

- As the family members, we are committing to the full eight (8) weeks of treatment.

Signature: _____ Date: _____

Signature: _____ Date: _____

- As the referring/support Worker, I am committing to the full eight (8) weeks of treatment.

Signature: _____ Date: _____

- As CJAY staff, we are committing to the full eight (8) weeks of treatment:

Signature: _____ Date: _____

Signature: _____ Date: _____



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COMMITMENT TO CARE

List who will be involved in the clients after care plan, of which outreach will be in contact with to develop a plan. The plan will be monitored once the client leaves treatment and up to two years.

Professional and/or family role:	Name: Address: Email: Phone number:
Professional and/or family role:	Name: Address: Email: Phone number:
Professional and/or family role:	Name: Address: Email: Phone number:
Professional and/or family role:	Name: Address: Email: Phone number:

PRE-ADMISSION MEDICAL ASSESSMENT FORM

Legal Client Name: _____	Preferred Name: _____
Prov. Health Card #: _____	Status/Beneficiary #: _____
Date of Birth: _____	
Home Address: _____	

Postal Code: _____	
Home Phone #: _____	

To the Physician:

The above named client is to be medically assessed as a requirement for the participation in a residential treatment program at Charles J Andrew Youth Treatment Centre, Sheshatshiu, NL for Alcohol/Drug/Inhalant Abuse/ Dependency.

Charles J Andrew requires each client to have a complete physical examination prior to admission.

1. Please provide any pertinent medical history that should be available to a health care provider should the client need health care while at treatment.

2. Is the client on any medication? Yes/no
If yes, please list the name of the medication, the dose etc. _____

3. Does the client have any allergies? Yes/no
Comments: _____

4. Does the client have any dietary restrictions? Yes/no
If yes, do they require medication for this?

5. Does the client currently have a communicable disease that would be a risk to others?
Yes/no

6. Has the client been checked and cleared for lice and scabies? Yes/no
If yes have they been treated? _____

Has the client been checked and cleared for MRSA? Yes/no
If yes have they been treated? _____

7. Tuberculosis:

a) Does the client have any signs or symptoms consistent with active Tuberculosis?
Yes/no

If yes ensure that the client is investigated for TB and is not infectious before entering the treatment centre.

b) Date and result of the most recent Tuberculin skin test (TST): _____

c) Date and result of the most recent chest x-ray if TST is positive: _____

8. Is the client pregnant? Yes/no

9. Are you aware of any additional medical conditions or limitations that may influence the clients' participation in the program? Yes/no

If yes, please explain:

10. Please provide an up to date copy of the clients immunization record

I hereby certify that I have examined the above named as required and the said person is physically and mentally fit to undertake the treatment program offered by Charles J Andrew Youth Treatment Centre.

Physician's Name: _____

Please Print

Address: _____

_____ Postal code _____

Telephone: _____ Fax: _____

Physician's signature: _____