Therapeutic Recreation Program Application

Richmond Mental Health
Consumer and Friends' Society (RCFC)

210-7671 Alderbridge Way, Richmond, BC V6X 1Z9
Ph: (604) 675-3977 Fax (604) 214-0947

Therapeutic Recreation Program
Participant Information

Name: ___________________________________

Address: ____Birth date:__________________________

Phone: _____________________ Email:__________________ Medical Services Plan # _________________

Persons to be contacted in case of an emergency

	Name Please Print	**Phone**
Relative/partner:	__________________________________	________________________________
Family Doctor:	__________________________________	________________________________
Psychiatrist:	__________________________________	________________________________
Mental Health Worker:	__________________________________	________________________________
Other:	__________________________________	________________________________

Allergies: (Please list all known allergies, including food, insect bites, vegetation etc and their effects)

Physical Health: (Please list any health considerations pertinent to leisure activity and exercise. Eg: diabetes, physical injuries or limitations, seizures, high blood pressure, ect)

Environmental "Stressors" (Please describe any situations or environmental stimuli which may cause undue stress, anxiety or fear etc and therefore should be avoided.)

Medications: (Please list all medications and what they are for. Eg: insulin for diabetes)

Acknowledgement & Consent

By signing below, I acknowledge that to the best of my knowledge the information provided on this form is complete and accurate, and will be kept in secure confidence by the Recreation Program Coordinator and Leaders employed by Richmond Mental Health Consumer & Friends Society.

I further understand and accept that the program is expressly for adults in recovery from a mental illness with no recent history of unsafe behaviour, and that my ongoing **voluntary** participation may be conditional on corroboration of that diagnosis by my doctor or mental health professional.

I further understand and agree that in the event of a psychiatric, medical or other emergency situation the information will be provided to third parties only as RCFC staff deem necessary for my safety and care.

	Name Please Print	**Signature**
Participant:	______________________	______________________
Witness:	______________________	______________________
Date signed:	______________________	______________________

Richmond Mental Health
Consumer and Friends' Society (RCFC)

210-7671 Alderbridge Way, Richmond, BC V6X 1Z9
Ph: (604) 675-3977   Fax (604) 214-0947

Therapeutic Recreation Program
Safety Rules & Requirements and Release of Responsibility

Please note *that this form may affect your legal rights.*
The reasons that it might affect them will be fully explained to you prior to signing.

I, the UNDERSIGNED, hereby acknowledge and accept that certain **RISKS OF INJURY** are inherent to participation in sport and recreational activities. I also acknowledge that these injuries may be minor or serious, and may result from one's own actions, the actions or inactions of others, or from a combination of both.

I acknowledge and understand that participation in the Recreation Program and any of its activities is **voluntary**.

I further acknowledge and understand that the Program's **SAFETY RULES & REQUIREMENTS** are expressly designed to safeguard all participants from the risk of injury, or loss or damage to their personal property, and hereby undertake to abide by them as described below **and/or** as directed by RCFC staff and/or Program-qualified volunteers.

1. *For all planned recreational activities requiring injury prevention equipment (eg: helmets for cycling) staff will exercise the right to deny participation to those individuals who arrive without the activity's specified safety equipment whenever that non-compliance is deemed to place their safety, or that of the group, at risk.*

2. *Participants shall respect the leadership and instructions of all staff and authorized volunteers, and adhere to any and all safety regulations of the activity and of the facility where the activity is being held. Unless instructed otherwise, participants are required to stay together or inform leaders of their whereabouts if they must separate.*

3. *Participants are responsible for bringing and administering their own medications and/or treatment plans on any full or half day activity. Only in the event of a medical emergency, or the onset of a precipitating condition, shall staff exercise the right to disclose all relevant health information and emergency contacts to third party health professionals.*

4. *Participants are required to conduct themselves in a safe and responsible manner at all times. Failure to do so will result in either finding alternative recreation activities, limiting the length of the activity, or temporary or indefinite dismissal from the recreation program, as deemed appropriate by recreation by recreation staff, manager and/or board of directors.*

I also understand and accept that a minimum **LEVEL OF FITNESS AND HEALTH** (physical, mental and emotional) is required for participation in Program activities, and **hereby declare** that my fitness and health levels are adequate for safe participation in the Program's activities. I further understand that a realistic self-assessment of these levels is necessary for my own enjoyment and safety, as well as that of the group. In the event of differing opinions on my fitness or health capacity I understand and accept that **THE OPINION/ ASSESSMENT OF THE ACTIVITY LEADER MUST PREVAIL.**

Release of Responsibility

I understand and accept that non-compliance with all or any Program safety rules and/or requirements **ON MY PART** shall automatically save and absolve the Richmond Mental Health Consumer & Friends Society and/ or its assigns from all and any responsibility for any injury, loss or damage consequently incurred. **UNLESS** such injury, loss or damage is found to be a consequence of **PROVEN NEGLIGENCE** on the part of the Richmond Mental Health Consumer & Friends Society and/or any of its employees, Board members, and volunteers while acting within the scope of their respective duties and responsibilities.

I have read the Therapeutic Recreation Program's **Safety Rules & Requirements and Release of Responsibility** in their entirety and hereby agree that I am participating in full knowledge and understanding of them and their purposes. I also affirm that the ways in which this form could affect my legal rights have been explained to me, and that I fully understand them.

	Name Please Print	**Signature**
Participant:	________________________	________________________
Witness:	________________________	________________________
Date signed:	________________________	________________________

Richmond Mental Health
Consumer and Friends' Society (RCFC)

210-7671 Alderbridge Way, Richmond, BC V6X 1Z9
Ph: (604) 675-3977 Fax (604) 214-0947

CONSENT FOR RELEASE OF INFORMATION FORM

Richmond Mental Health Consumer and Friends Society (RCFC), respects and upholds an individual's right to privacy. In order to safeguard client confidences, RCFC acts within the constraints of the law and policies of the Richmond Health Services, and have attached their brochure about the "Freedom of Information and Protection of Privacy Act".

Please note that in order to determine eligibility, mental readiness and safe behavior within a group or community setting, it may be necessary to contact the professional and discuss and/or receive information about you. Please indicate your consent to this process below. Your information will be maintained as a confidential, secure record.

For the purposes stated above, I, ____ (print)
give consent to authorized representatives of Richmond Mental Health Consumer and Friends Society, to contact:

Name: ________________________________ Title: ________________________________

Address: ____

Phone: ________________________________ Fax: ________________________________

This consent from remains valid for the duration of the individual's participation in the program up to one year from the date signed.

Date: ________________________________ Signed: ______________________________

Date: ________________________________ Witness: ______________________________
(Indicate: Physician, Mental Health Professional, or RCFC Staff)

REFERRAL FORM
For RCFC Programs
(to be completed by Physician or Mental Health Professional)

210-7671 Alderbridge Way, Richmond, BC V6X 1Z9
Ph: (604) 675-3977 Fax (604) 214-0947

<table>
<tr><td colspan="6">Name of Client being Referred to RCFC:</td></tr>
<tr><td colspan="4">Physician or Mental Health Professional in case of an emergency:</td><td colspan="2">Telephone Number:</td></tr>
<tr><td colspan="4">Client has been diagnosed with a Mental Health Condition by a doctor or psychiatrist</td><td>Yes:</td><td>No:</td></tr>
<tr><td>History of Physical Aggression</td><td>Yes</td><td>No</td><td>N/K</td><td colspan="2">If yes, please describe, with date of the last known incident:</td></tr>
<tr><td>Other behavior(s) That may pose a safety risk</td><td>Yes</td><td>No</td><td>N/K</td><td colspan="2">If yes, please describe, with date of the last known incident:</td></tr>
<tr><td colspan="6">Given what you know about your client, do you feel he/she is ready at this time to participate with other peers, either at the mental health TEAM or in the community?</td></tr>
<tr><td colspan="6">If incidents (above) have been minor, do you have any recommendations on how these can best be prevented?</td></tr>
<tr><td colspan="3">Your name (print):</td><td colspan="3">Signature:</td></tr>
<tr><td colspan="3">Title/position:</td><td colspan="3">Date:</td></tr>
</table>