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 CONSIDERATON of the CHARLES J ANDREW YOUTH and FAMILY TREATMENT CENTRE accepting me to be a participant of the Nutshimit Program, I _____, my heirs, and executers, 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, gents, 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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Consent to Building Surveillance

Please be advised there is a security/surveillance system that has been put in place at our centre and is in use, recording 24 hours a day, 7 days a week at the Charles J. Andrew Healing Centre.

Description of the security surveillance system function:

The surveillance system is used to prevent/discourage persons from damaging property and to provide security to the staff and clients attending the Charles J. Andrew Healing Centre. The 5 surveillance cameras record the perimeter of the building, exits and surrounding grounds.

By signing below, you as the client understand why the security/surveillance system has been put in place and understand that yourself and your family members may be recorded by the system while attending the Charles J. Andrew Healing Centre.

_____

Client Name

_____

Client Signature

_____

Names of Family Members

_____

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: _____