



Federation of BC Youth In Care Networks

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Steering Committee Registration Form (Member)

SCM # _____

DATE: _____

LOCATION: _____

Privacy: The personal information collected with this form is used by the FBCYICN to ensure the safety and well-being of all participants at the Steering Committee Meeting (SCM). We may need to contact you/your guardian (social worker) to clarify or ask questions about things you put on this form so we can determine what kind of supports you need. We may also need you to help us identify additional supports (i.e. a support person) to attend the SCM. The contact information you provide is also used to send updates and information to you. This information will not be shared with individuals or other organizations. For more information, check the website or contact the office. IMPORTANT: Leaving any question blank is not an option. If any question is blank, the registration form will be considered incomplete.

Participant Contact Information

First Name _____ Last Name _____

Birthdate _____ MONTH / DAY / YEAR _____ Age _____

Gender Male Female Other (please specify) _____

Address _____ City _____

Province _____ Postal Code _____

(1) Phone # _____ (2) Phone # _____

email _____

Which is best method for contact: Phone Email Other (please specify) _____

Is this your first SCM: Yes No Do you want to become a Youth in Care Network Member: Yes No

Members receive updates and information about opportunities. They can also vote at Annual General Meetings.

Caregiver or (Legal) Guardian Contact Information (OR Emergency Contact Info – if you're over 19)

First Name _____ Last Name _____

Relation _____

Address _____ City _____

Province _____ Postal Code _____

(1) Phone # _____ (2) Phone # _____

email _____

The above-identified caregiver or emergency contact MUST be available 24 hours a day for the entire weekend.

Social Worker

First Name _____ Last Name _____

Address _____ City _____

Province _____ Postal Code _____

Phone # _____ Fax # _____

email _____

Funding Information

Do you require a subsidy to attend?

- Yes Full Subsidy – (Fee, travel, meals, daycare, other – please specify: _____)
 Partial Subsidy – (Fee, travel, meals, daycare, other – please specify: _____)

No Invoice for the conference should be sent to:

- Social / Youth Worker Caregiver Other: _____

Name _____

Address _____ Phone Number: _____

Please note invoices will be sent out to the above after the SCM – payment is due 30 days after the SCM. Payment is accepted by cheque.

Travel Details

I will be going... (Choose 1)

- To the office to meet the bus to the camp (Must arrive at the office by no later than 3:30pm)
 To the airport or bus terminal and need to arrange transportation to / from the office
 Straight to the Camp _____ Estimated Time of Arrival (please note the meeting begins at 5:00pm on Friday evening)

Additional Travel Information: _____

Note: Please DO NOT book travel until you have been approved to attend the Steering Committee Meeting. A FBCYICN staff member will contact you regarding approval and travel details and if participants are flying or traveling by bus, they must arrange their travel times with us in advance to booking.

Health Information

This information is collected to ensure the safety, health and well-being of all participants at the SCM. It is important that all the questions are answered honestly and completely. The FBCYICN can only provide appropriate support, assistance and intervention based on the information provided. Leaving any question blank is not an option as the FBCYICN must be aware of all health information. If we discover we have not been advised of important health information in advance, FBCYICN reserves the right to refuse a participant from attending.

Care Card Number (must provide in case of emergency): _____

Do you have any dietary restrictions?

- No Yes (if yes check boxes that apply)

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Vegan (no animal products) | <input type="checkbox"/> No Poultry |
| <input type="checkbox"/> Vegetarian (no meat) | <input type="checkbox"/> No Seafood |
| <input type="checkbox"/> Lacto-ovo Vegetarian (diary and eggs only) | <input type="checkbox"/> No Dairy |
| <input type="checkbox"/> No Red Meat | <input type="checkbox"/> No Nuts |
| <input type="checkbox"/> No Pork | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Other: _____ | |

Note: If there is nothing marked down on the registration form you will not be provided a special dietary meal at the SCM. A list is kept by the staff and camp of who has dietary restrictions and this list will be enforced.

GUARDIAN'S INITIAL AS VERIFIED: _____

Do you have any allergies? No Yes (if yes check boxes that apply)

Hay Fever (e.g. Dust, grass, pollen) please specify: _____

Animals (e.g. Cats, dogs) please specify: _____

Insects (e.g. Bees, spiders) please specify: _____

Medications (e.g. aspirin, penicillin) please specify: _____

Foods – please specify: _____

Other allergies not listed above: _____

Severity of allergy: _____

Do you take medication(s) to treat your allergies or have special procedures: No Yes

If yes please specify name of medication and dose or other options: _____

GUARDIAN'S INITIAL AS VERIFIED: _____

Do you have any Medical / Health Conditions? No Yes (if yes check boxes that apply)

Physical Disability – please specify disability and what supports will be needed to ensure full participation: _____

Asthma Heart Disease Hepatitis A/B

Diabetes Epilepsy Hepatitis C

Pregnant Addiction HIV / AIDS

Other health conditions not listed above: _____

Do you take medication(s) to treat your health conditions or have special procedures? No Yes

If yes, please specify name of medication and dose or other options: _____

GUARDIAN'S INITIAL AS VERIFIED: _____

Do you have any Mental Health Concerns / Conditions? No Yes (if yes check boxes that apply)

Attention Deficit (ADD/AHAD) Anxiety Disorder Schizophrenia Self Harm

Depression Obsessive Compulsive (OCD) Fetal Alcohol Anger Issues

Other Mental Health concerns / conditions not listed above (please specify) _____

Do you take medication(s) to treat your mental health concern or condition or have special procedures: No Yes

If yes please specify name of medication and dose or other options: _____

GUARDIAN'S INITIAL AS VERIFIED: _____

Do you have any Visible or Invisible Disabilities? No Yes, If yes, please specify: _____

GUARDIAN'S INITIAL AS VERIFIED: _____

Do you need additional supports / caregivers during the SCM for your daily needs (eg: dressing, daily activities, etc) No Yes

If yes please describe what is needed by the supports or caregivers? _____

GUARDIAN'S INITIAL AS VERIFIED: _____

Do you have good social/sexual boundaries? Yes No Please describe: _____

GUARDIAN'S INITIAL AS VERIFIED: _____

Have you been convicted of a criminal offence? No Yes, If yes, please describe: _____

GUARDIAN'S INITIAL AS VERIFIED: _____

Is your life currently stable? (i.e. stable housing, etc.) Yes No Please describe: _____

GUARDIAN'S INITIAL AS VERIFIED: _____

Do you have any other needs or concerns that the FBCYICN should be aware of or may need to provide special attention for:

No Yes, If yes, please describe: _____

Are you taking any other medications?

No Yes, If yes, give the name of medication and dosage instructions (including refrigeration instructions): _____

Are you allowed to give yourself your own medications while at the SCM?

Yes No, If no, please give details of the assistance you require? _____

Are you able to hold on to your medications while at the SCM? Yes No

Please bring all medications in the original packaging. Prescription medication should have labels showing what the medication is, who it is for and the dosage.

Code of Conduct

The Code of Conduct applies to all participants at the SCM. It was developed by young people to keep everyone safe and comfortable at all Networking events.

NO Alcohol or Drugs – All Networking events are substance free

NO Sexual Intimacy – Please maintain and respect strict personal boundaries

NO Weapons – Please leave anything that might be considered a weapon at home

NO Violence or Disrespect – There is zero tolerance for discrimination, racism or homophobia

NO Room Visits – Please stay out of other people's rooms / cabins

NO Leaving the Event Site – Please remain on-site for the duration of the event

NO Age-Exclusionary Establishments – Please stay out of areas (bars, clubs, etc.) that exclude minors

The FBCYICN is not responsible for lost or stolen items. Please do not bring valuable items to Networking events unless arrangements for securing the item(s) have been made with FBCYICN staff in advance.

If you have any questions about the Code of Conduct, or how it applies to your (or any other participant) please call the office.

By signing below, I understand that:

1. The SCM is a combination of recreational activities, group activities, meetings, consultations, workshops, and FBCYICN business and I am willing to participate in all of these kinds of activities,
2. My participation may be restricted, or I may be required to leave the SCM if the questions on this registration form have not been answered completely and honestly or if I break the Code of Conduct.
3. If I do require special attention or do need a caregiver for daily activities that it is my responsibility to have someone available for my needs.
4. I must tell the Administrative Coordinator of any changes to the information provided on the registration form BEFORE my arrival at the camp.
5. If I am under 19, the FBCYICN may contact my caregiver and/or Social/Youth worker to confirm the information provided
6. By signing, I confirm that all information provided on the registration form is accurate and complete and that I have read and understand the Code of Conduct.

Participant Signature: _____

Guardian Signature (if under 19): _____

FBCYICN Office use Only

Phone Registrations

Statement was read to and acknowledged by the participant?

Yes

Read by:

Date:

Time:

Participants Under 19

Caregiver of Guardian has confirmed the information is correct?

Yes

No

Contacted by:

Date: