

MANITOBA FASD

FamilyNetwork



## **FASD Explore Summer 2018 Summer Application Package July 11–13, 2018**

Applications are due Friday, May 18, 2018

**\*\*Please submit your application as soon as possible to ensure a spot \*\***

Families will be contacted by phone regarding application status between  
May 28 to June 1, 2018

**NOTE:** If the child is in care, forms must be signed by the CFS worker before the application will be accepted.



**Please take the time to properly fill in, date, and sign the following documents:**

- Explore Summer 2018 FASD Summer Camp Application form (Form A)
- Photo consent (Form B)
- Exchange of information (Form C)
- Medical information form (3 pages) - Momenta *experience discover grow*
- Waiver and Release of Liability form—Momenta *experience discover grow*

**\* Total pages to return = 7 pages**

**Mail or fax applications to:**

MB FASD Family Network Attn: Rita Drohomereski  
Rehabilitation Centre for Children  
Specialized Services for Children and Youth Centre  
1155 Notre Dame Avenue  
Winnipeg, MB R3E 3G1  
Fax: (204) 258-6797

**Questions?** Please contact Laura Bennett at:  
Phone (204) 258-6741  
Email [lbennett@rccinc.ca](mailto:lbennett@rccinc.ca)

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Specialized Services  
for Children & Youth  
Together is Better

Rehabilitation Centre for Children  
1155 Notre Dame Avenue  
Winnipeg, MB, Canada R3E 3G1  
Tel: (204) 452-4311 Fax: (204) 477-5547  
Web: www.rccinc.ca email: info@rccinc.ca



## CONSENT FOR PHOTOGRAPHS - FASD Summer camps July 11-13, 2018 (Form B)

Date: \_\_\_\_\_

In connection with (Client's name): \_\_\_\_\_

I consent to having photographs taken for the purpose of:

YES \_\_\_ NO \_\_\_ Providing participants with a **printed memory album** of their summertime camp and friendship experiences.

For Your Consideration: All participants in our FASD adolescent recreation programs agreed to a memory album, and this proved to be a very positive strategy. The pictures solidified friendships and provided participants with a visual way to share the summer experience with caregivers.

YES \_\_\_ NO \_\_\_ Using photos in **educational presentations** of the Manitoba FASD Centre or the Rehabilitation Centre for Children to promote recreational programs for youth with FASD.

Comments/Restrictions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**This consent shall act to expressly release from liability the Rehabilitation Centre for Children Inc., its agents and the photographer.**

\_\_\_\_\_  
Name and Signature of Client (as appropriate)

\_\_\_\_\_  
Name and Signature of Witness

\_\_\_\_\_  
Name and Signature of Legal Guardian

Unless notified by legal guardian in writing, this form will remain valid for 2 years from the date signed.

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## Consent for Exchange of Information (Form C)

I give permission for the Rehabilitation Centre for Children (RCC), including the programs of the Manitoba Fetal Alcohol Spectrum Disorder Centre (MB FASD Centre) to send and receive information to the services listed below. I understand that the information collected and distributed below will be for the purposes of assessment, planning and developing programs for my child and used in collecting non-identifiable data for planning, and program evaluation related to the provision of services.

**Program:** *Summer Explore camp Summer 2018 FASD Family Network and Stepping Out on Saturday Manitoba (SOS MB) Camps running July 11-13, 2018*

Service/Agency (Add Name and address if known)

- ✓ Manitoba FASD Centre: SSCY Centre 1155 Notre Dame Ave.
- ✓ School & School Division: \_\_\_\_\_
- ✓ Foster Parents: \_\_\_\_\_
- ✓ Service Coordinator (CDS, SMD, CFS) \_\_\_\_\_
- ✓ Program provider: Momenta: experience discover grow. PH. (204) 250-8749, Address: 984 Portage Ave, Winnipeg MB.
- ✓ Other: \_\_\_\_\_

Is there anyone else that you **do not** want us to exchange information with? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Name of Legal Guardian

\_\_\_\_\_  
Name of Witness

\_\_\_\_\_  
Signature of Legal guardian

\_\_\_\_\_  
Signature of Witness

Date: \_\_\_\_\_

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904 PORTAGE AVE.  
WINNIPEG, MB R3G 0R6

EXPERIENCEMOMENTA.COM

F / 204.308.9722

ENTRANCE ON ALBERT ST.

F / 204.415.4327



Program:

Date:

Participant Name \_\_\_\_\_

Birthdate of Participant \_\_\_\_\_ Age \_\_\_\_\_ Gender/Pronoun: \_\_\_\_\_

Languages spoken \_\_\_\_\_

Mailing Address \_\_\_\_\_

Name of Parent(s) or Guardian(s) \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work or Cell Phone (\_\_\_\_) \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Doctor's Phone (\_\_\_\_) \_\_\_\_\_

Manitoba Health Number \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work or Cell Phone (\_\_\_\_) \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work or Cell Phone (\_\_\_\_) \_\_\_\_\_

General Medical History

Does participant have a history of	Yes	No
1. Respiratory problems		
2. Asthma		
3. Gastrointestinal disturbances		
4. Diabetes		
5. Blood disorders		
6. Neurological problems		
7. Seizures		
8. Dizziness, fainting		
9. Migranes		
10. Disorders of urinary tract		
11. Hypertention		
12. Cardiac problems		
13. Fractures		
14. Sprains		
15. Other joint or muscle injury		

Does participant have a history of	Yes	No
16. Allergies to foods		
17. Dietary restrictions		
18. Environmental allergies		
19. Allergies to Medications		
20. Treatment for menstrual cramps		
21. Pregnant		

If YES to 1-21, please complete the next table. Attach a separate sheet if necessary.

Number	Specifics

	Yes	No
22. Is the participant bringing medication to the program?		

If YES to 22, please complete the next table. Attach a separate sheet if necessary.

Medication	Dosage amount	Time of day	For what condition

Momenta's health officer will provide OTC medications for minor illnesses/complaints. Please initial the medications below that your child may be given if deemed necessary:

- Pain/Fever Relief (Tylenol, Ibuprofen)
- Antihistamines (Benadryl)
- Cold/Cough (cough syrup, cough drops)
- Topical (antibacterial ointment, Calamine)
- Stomach Upset (Pepto, TUMS)

Personal History

Is the participant currently experiencing:	Yes	No
23. Addiction to tobacco cigarettes		
24. Substance abuse		
25. Eating disorder		
26. Anxiety disorder		
27. Depression		

Is the participant currently experiencing:	Yes	No
28. Behaviour disorder		
29. Trouble sleeping or sleep disorders		
30. Impacts from a history of trauma or a traumatic event		
<p>If YES to 23-29 include triggers, reactions and treatment            *Please note that if your child is addicted to smoking tobacco cigarettes, cigarettes and lighters must be handed in on the first day of camp. Please note how you would like camp staff to manage this addiction for the duration of camp.</p>		

31. What is the participants' fitness level? Above Average    Average    Below Average

32. What is the participants' swimming level? Above Average    Average    Non-swimmer

33. Date of last tetanus shot \_\_\_\_\_

34. What is the participant's t-shirt size (please circle) YouthMedium YouthLarge S M L XL XXL XXXL

By my signature, I attest all information on this form is complete, thorough and truthful.

Parent / Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_



