



# Therapeutic Recreation Program APPLICATION PACKAGE

**Address:** 210 - 7671 Alderbridge Way, Richmond, BC V6X 1Z9  
**Phone:** 604-675-3977 | **Fax:** 604-214-0947 | **Web:** [www.vch.ca/rcfc](http://www.vch.ca/rcfc)

## PARTICIPANT INFORMATION

<b>First Name</b>				<b>Last Name</b>			
<b>Address</b>							
<b>City</b>			<b>Province</b>			<b>Postal Code</b>	
<b>Phone</b>				<b>Email</b>			
<b>Birth date</b>				<b>Medical Services Plan #</b>			

## EMERGENCY CONTACTS

**NAME** (PLEASE PRINT)

**PHONE**

**Relative/Partner:** \_\_\_\_\_

**Family Doctor:** \_\_\_\_\_

**Psychiatrist:** \_\_\_\_\_

**Mental Health Worker:** \_\_\_\_\_

**Other:** \_\_\_\_\_

**Allergies** - List all known allergies, including food, insect bites, vegetation, etc **and their effects**

**Physical Health** - List any health considerations pertinent to leisure activity and exercise (e.g., diabetes, physical injuries or limitations, seizures, high blood pressure, etc)

**Environmental Stressors** – Describe any situations or environmental stimuli which may cause undue stress, anxiety or fear, etc (and therefore should be avoided)

**Medications** – List all medications **and what they are for** (e.g., 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 the Richmond Mental Health Consumer and Friends' Society (RCFC).

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**

**DATE SIGNED**

**Participant:** \_\_\_\_\_

**Witness:** \_\_\_\_\_

## 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 sports 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 Therapeutic Recreation Program ("Recreation Program" or "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 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 the Richmond Mental Health Consumer and Friends' Society (RCFC) staff and/or Program-qualified volunteers.

1. *For all planned recreational activities requiring injury prevention equipment (e.g., 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 activities, limiting the length of the activity, or temporary or indefinite dismissal from the recreation program, as deemed appropriate 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 RCFC 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 RCFC and/or any of its employees, Board members, and volunteers while acting within the scope of their respective duties and responsibilities.

**NAME** (PLEASE PRINT)

**SIGNATURE**

**DATE SIGNED**

**Participant:** \_\_\_\_\_

**Witness:** \_\_\_\_\_



## CONSENT FOR RELEASE OF INFORMATION

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 "Freedom of Information and Protection of Privacy Act" ([https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96165\\_00](https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/96165_00)).

Please note that in order to determine eligibility, mental readiness and safe behaviour 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, \_\_\_\_\_ **[PLEASE PRINT YOUR NAME]**, give consent to authorized representatives of RCFC to contact:

<b>Name</b>					
<b>Title/Position</b>					
<b>Address</b>					
<b>City</b>		<b>Province</b>		<b>Postal Code</b>	
<b>Phone</b>			<b>Fax</b>		

This consent remains valid for the duration of the individual's participation in the program.

**NAME** (PLEASE PRINT)

**SIGNATURE**

**DATE SIGNED**

**Participant:** \_\_\_\_\_

**Witness\*:** \_\_\_\_\_

**\*Indicate:**  Physician  Mental Health Professional  RCFC Staff  Other (specify): \_\_\_\_\_



## REFERRAL FORM FOR RCFC PROGRAMS

(To be completed by Physician or Mental Health Professional)

<b>Name of Client being referred to RCFC</b>	
<b>Name of Physician or Mental Health Professional (in case of an emergency)</b>	<b>Phone</b>
<b>History of physical aggression</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>If Yes, please describe, with date of last known incident</b>	
<b>Other behaviour(s) that may pose a safety risk</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>If Yes, please describe, with date of last known incident</b>	
<b>Given what you know of about your client, do you feel they are ready at this time to participate with other peers, either at the Mental Health Team or in the community?</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>If incidents (above) have been minor, do you have any recommendations on how these can best be prevented?</b>	
<b>Your Name (please print)</b>	
<b>Title/Position</b>	
<b>Date</b>	
<b>Signature</b>	