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PROGRAM ENROLMENT FORM

PROGRAM JOINING: _____

LOCATION: YARRA JUNCTION / WARRAGUL / ONLINE

IS THE PARTICIPANT A CURRENT OR NEW CLIENT TO SMP? CURRENT / NEW

CLIENT INFORMATION

CHILD'S NAME: _____

PREFERRED NAME: _____ **DATE OF BIRTH:** _____ **AGE:** _____

PARENT/CARER 1: _____ **PHONE:** _____

PARENT/CARER 2: _____ **PHONE:** _____

ADDRESS: _____

EMAIL ADDRESS: _____

Primary Language Spoken at Home: _____ **Other:** _____

Does your child identify as Aboriginal or Torres Strait Islander?

☐ Yes - Aboriginal ☐ Yes - Torres Strait Islander ☐ No

FUNDING: NDIS / FAHCSIA / MEDICARE / PRIVATE HEALTH / FAMILY

EDUCATIONAL INFORMATION

SCHOOL: _____ **GRADE:** _____ **TEACHER:** _____

FAMILY INFORMATION

Who lives at home? Are there any parenting plans or court orders in place? YES ☐ NO ☐ If YES, please provide a copy to the SMP team prior to confirmation of your place in the program.

_____

_____

MEDICAL & DEVELOPMENTAL HISTORY

MEDICAL: Please list allergies, ongoing illnesses, prescribed medications, vision or hearing problems.

Does your child have a current medical plan? YES ☐ NO ☐ If YES, please provide a copy to the SMP team.

_____

_____

DEVELOPMENTAL: Does your child have a diagnosis? Are there other professionals in your support team?

_____

_____

GOALS / MAIN CONCERNS: _____

_____

_____

PARENT/CARER DECLARATION

I/We give consent for my/our child _____ to participate in the _____ Program facilitated by Psychologist and Provisional Psychologist team members of Strong Minds Psychology. This permission remains for as long as involvement is deemed necessary. I/We understand that consent can be withdrawn at any stage.

I/We agree to attend all sessions of the program & will provide notice to the Strong Minds Psychology team if we are unable to attend any sessions.

Sharing/Receiving relevant information:

I/We consent for the facilitating clinicians to discuss, obtain or share relevant information with parents/carers, as well as the following professionals. I/We give permission for a copy of any professional reports to be forwarded to the organisations or professionals listed below.

Contact Details: Name: _____ Phone: _____ Email: _____

Contact Details: Name: _____ Phone: _____ Email: _____

Photography & Social Media/Advertising:

Occasionally photos or video will be taken in the course of sessions, either to help with modelling of skills, or to show the positive experience of program participants. Please indicate below if you give consent for photos or videos to be taken of your child during the program, and if you give consent for photos to be used on social media or advertising. (please circle your choice or delete the not relevant option)

I/We DO/DO NOT consent for photos and videos to be taken of my/our child

I/We DO/DO NOT consent for photos of my/our child to be used on social media or advertising

I/We understand that a confidential file will be created (or combined with the current file) which will contain information deemed relevant to my child. This file will be retained securely until my child is 25 years old, or seven years after completion of psychological intervention if they remain a client after the age of 18 years.

Parent/Carer 1 Signature: _____ Date: _____

Parent/Carer 2 Signature: _____ Date: _____