CMHA- Cowichan Valley Branch
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Rainbows
GUIDING KIDS THROUGH LIFE'S STORMS

CHILDREN'S SUPPORT GROUP

(Child's)
Participant's Name:_____

M❑ F❑ Age:__ __ Birthdate:_____Grade:_ ___ School:_____

Parent/Guardian Name:_____

Address:__ _____ City_____postal code_____

Phone:(H)___ _____(W)_____(cell):_____

E-mail:_____

Emergency contact:_____Relationship to child_____

Phone:_ _____

Name of siblings	Age	living at same address: yes	no	Also attending Rainbows:	yes	no

Allergies/Medical information regarding your child we should be aware of. / Name of Family Doctor:

_____

Description of loss(es) of the child: ❑Death ❑Separation ❑Divorce ❑Other _____

Date(s) Loss(es)/ changes occurred _____

Other information you would like us to know (all info stays confidential)_____
_____
_____
_____

Who else has permission to pick up your child? _____ Relationship:_____

Parent / Guardian Signature:_____

Please inform us if there is anyone who is NOT allowed in the building while your child participates in Rainbows: Name(s) & relationship to child:

_____