PARTICIPANT FILE CODE:_____ (DEJE 01011980 F BNFC UAHL)
Jane Doe, Month, Day, Year, Female/Male, OFIFC Centre, Urban Aboriginal Healthy Living

Urban Aboriginal Healthy Living Program
PROGRAM REGISTRATION FORM

PARTICIPANT CONTACT INFORMATION: (Please Print)

Name:	Sex: (Please Circle) Male / Female
Birth Date: (M/D/Y)	
Address:	City & Province:
Postal Code:	E-mail Address:
Home Telephone:	Cell Phone:
Status: ( ) Non-Status ( ) Metis ( ) Inuit ( ) First Nation	
Dependant(s) (Dependants of Participants do not require a registration or intake form if 17yrs and under)	
Dependant Name:	Birth Date (M/D/Y):
Dependant Name:	Birth Date (M/D/Y):
Dependant Name:	Birth Date (M/D/Y):
Dependant Name:	Birth Date (M/D/Y):
Additional Dependant's Please Attach a Separate Sheet	

EMERGENCY CONTACT INFORMATION: (Please Print)

Name:	Relationship:
Address:	City & Province:
Postal Code:	E-mail Address:
Home Telephone:	Cell Phone:

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PARTICIPANT ASSUMPTION OF RISK, RELEASE AND WAIVER OF LIABILITY

As consideration for the opportunity to use the property, facilities, equipment, and/or services of the **BARRIE NATIVE FRIENDSHIP** centre and/or to participate in any of the scheduled program activities, I acknowledge that I have read the following and voluntary agree to its terms and conditions:

URBAN ABORIGINAL HEALTHY LIVING PROGRAM WAIVER / LIABILITY CONSENT	
I am at least 18 years of age ***(If not, please see below)***	YES □ or NO □
I understand and agree that my participation in all UAHL programs is strictly voluntary.	YES □ or NO □
I understand and agree to the use of the Urban Aboriginal Healthy Living Program's property, facility, equipment, and/or services are strictly voluntary.	YES □ or NO □
I acknowledge as part of injury prevention, it is my responsibility to inform the Urban Aboriginal Healthy Living Worker of my physical limitations and/or injuries that may present me from participating and/or performing components of a program in advance.	YES □ or NO □
I understand that my use of the property, facilities, equipment, and/or services of the Urban Aboriginal Healthy Living Program and/or my participation in any activities present certain risks of injury including but not limited to, personal injury or death. Understanding the risk involved, I knowingly and voluntary chose to take these risks in order to use the property, facilities, equipment, and/or services of the Urban Aboriginal Healthy Living Program and/or to participate in program activities.	YES □ or NO □
In case of emergency, accident, illness, or other incapacity which occurs while I am using the property, facilities, equipment, and/or services of the Urban Aboriginal Healthy Living Program and/or participating in program activities, I give my permission to be treated by a medical professional and admitted to a hospital, if necessary, I understand and agree that I am responsible for all medical and emergency expenses incurred on my behalf regardless of whether I have authorized such expenses.	YES □ or NO □

I have read and fully understand the ASSUMPTION OF RISK, RELEASE AND WAIVER OF LIABILITY and my signature below confirm my full understanding and voluntary acceptance of the conditions indentified above.

Participant Name: (Please Print)	Participant Signature:
Date:	Witness Signature:

Participants 17 years or under, parent / legal guardian consent & signature is required

I am the parent or legal guardian of the Participant name above; I have read and understand the foregoing ASSUMPTION OF RISK AND WAIVER OF LIABILITY (including such parts as may subject me to personal financial responsibility); I am and will be legally responsible for the obligations and acts of the Participant as described above and I agree, for myself and for the participant, to be bound by these terms.

Parent Name: (Please Print)	Parent's Signature:
Date:	Contact Telephone:

Logged by:

PARTICIPANT FILE CODE:_____ (DEJE 01011980 F UAHL)
Jane Doe, Month, Day, Year, Female/Male, OFIFC Centre, Urban Aboriginal Healthy Living

Urban Aboriginal Healthy Living Program
PRE-HEALTH & LIFESTYLE ASSESSMENT

The Purpose of this assessment is to identify varying participation levels of individuals while having consideration of medical history. Based on this preliminary information, the UAHL can develop and implement appropriate and safe programming for all participant levels. All the information provided, will be *STRICTLY CONFIDENTIAL* and will become part of your client file.

Client Name: (Please Print)		**Today's Date:** (D/M/Y)	
Dependent(s) (Dependents of Participants do not require a registration or intake form if 17 and under)			
Dependant Name:		Birth Date:	
Dependant Name:		Birth Date:	
Dependant Name:		Birth Date:	
ADDITIONAL DEPENDENTS PLEASE ATTACH A SEPARATE SHEET			
PRESENT STATUS			
Present Weight:	lbs/kg	Height: ft/cm	Sex: Male or Female
Target Weight:	lbs/kg	Comments:	

The Pre-Health & Lifestyle Assessment is categorized by six sections, **Goals, Lifestyle, Medical History Consideration, Nutrition, Physical Activity / Exercise and Injury Prevention**. Please provide detailed information to the best of your ability; this information will assist us in familiarizing your strengths and areas of limitations as well as determining your program participant level.

1. GOALS - This section indentifies your goals for participating in the UAHL.

☐ Become More Physical Active	☐ Learn Healthier Nutrition Meal Choices
☐ Youth Leadership Skills	☐ Diabetes Prevention and / or Care
☐ Weight Loss / Weight Gain	☐ Shaping & Toning
☐ Building Muscle	☐ Building Strength
☐ Overall Improved Health	☐ Lower Blood Pressure or Cholesterol
☐ Quit Smoking / Smoking Cessation	☐ Other:

2. LIFE STYLE - This section relates to how you live your life and respond to events around you.

Do you currently Smoke: If so, what is your smoking history? How many times in a day?	YES ☐ or NO ☐
Do you lead a sedentary lifestyle? Do you engage in physical activity / fitness regime? If so, how often?	YES ☐ or NO ☐
Do you have a regular sleep routine? How many hours of sleep per day?	YES ☐ or NO ☐
Do you feel you are experiencing excessive stress? If so, what do you do to alleviate stress from your life?	YES ☐ or NO ☐
Is there anything your lifestyle choices that may impact on your participation in the UAHL Program?	YES ☐ or NO ☐
ADDITIONAL NOTES:	

3. MEDICAL HISTORY / CONSIDERATIONS – This section relates to your medical history specifically identifying key indicators that may permit and/or limit involvement of a program. Remember, your *health & safety* is priority; therefore, please be honest when completing the following:

Are you over the age of 40?	YES ☐ or NO ☐
Has anyone in your immediate and/or extended family had a heart attack, stroke or cardiovascular disease?	YES ☐ or NO ☐
Have you had a physical examination from your doctor in the past year?	YES ☐ or NO ☐

Logged by:

Do you have a heart condition? If so, please provide details?	YES □ or NO □
Do you have any systematic disorders (mononucleosis, H.I.V., hepatitis, etc.) or Neuromuscular, musculoskeletal or rheumatoid disorders?	YES □ or NO □
Are you pregnant? If so, how many weeks / months?	YES □ or NO □
Have you had major surgery or illness within the last 6 months? If so please list:	YES □ or NO □
Are you currently taking medication? If so please provide details?	YES □ or NO □
Do you have emphysema?	YES □ or NO □
Do you have epilepsy?	YES □ or NO □
Do you have chronic bronchitis?	YES □ or NO □
Do you have asthma? If so, do you carry an inhaler?	YES □ or NO □
Have you ever lost consciousness or control of your balance due to Chronic dizziness? If so, explain.	YES □ or NO □
Has a physician ever told you or are you aware that you have high blood Pressure?	YES □ or NO □
Has a physician ever told you or are you aware that you have high Cholesterol level?	YES □ or NO □
Do you have diabetes? If so, which type? Please explain.	YES □ or NO □
Are there other detail that need awareness? (eg, tradition medicine) If so, please explain.	YES □ or NO □
ADDITIONAL NOTES:	

4. NUTRITION – Proper nutrition is the key to an overall improved health approach. Understanding nutrition pertaining to meal / snack portions and scheduled can enhance a physical fitness and cardiovascular routine.

Do you have a scheduled meal / snack routine? If so, provide details:	YES □ or NO □
Do you have any food allergies? If so, provide details:	YES □ or NO □
Have you preformed a body cleanse in the past? If so, name of cleanse	YES □ or NO □
Do you consume a minimum of 8 glasses of 8 ounces of water daily? If not, how much do you consume?	YES □ or NO □
Do you consume caffeinated drinks? (eg, coffee, teas, pop and energy drinks etc.) If so, how many?	YES □ or NO □
Do you consume fast food often? If so, how often?	YES □ or NO □
Do you know what proteins, complex carbohydrates are?	YES □ or NO □
Do you consume white / brown sugar, white flour, salt, and lard regularly? If so, please provide details.	YES □ or NO □
Do you know what the benefits are for whole foods, grains and greens? If so, please provide details.	YES □ or NO □
Do you consume fruits and vegetables daily? If so, please provide details?	YES □ or NO □
Do you take vitamins / minerals, supplements and / meal replacements? If so, please provide details.	YES □ or NO □
ADDITIONAL NOTES:	

5. PHYSICAL ACTIVITY / EXERCISE – Regular physical activity is safe for most people however, some individuals should check with their physician before they start an exercise program. To help us determine if you should consult with your physician before starting to exercise or participate in any of the UAHL activities, please read the following questions carefully and answer each one honestly. Following the below questions, please complete the attached PAR-Q form.

Has your physician diagnosed you with a heart condition? If so, are there specific exercises recommended by your physician for you to perform and/or avoid? If so, please provide details:	YES □ or NO □ YES □ or NO □

(Details):	
Do you feel pain in your chest when you do physical activity?	YES □ or NO □
In the past month, have you had chest pain when you were not doing physical activity?	YES □ or NO □
Do you lose your balance because of dizziness or do you ever lose consciousness?	YES □ or NO □
Do you have a bone or joint injury (eg back, knee and hip) that could be made worse by a change in your physical activity?	YES □ or NO □
Has your physician prescribed drugs (eg water pills) for your blood pressure or heart condition?	YES □ or NO □
Do you know of any other reason why you should not do physical activity?	YES □ or NO □
ADDITIONAL NOTES:	

6. INJURY PREVENTION – This section relates to injury prevention and identifying past and/or current injuries and physical limitations. Please be specific and provide as much detail as possible. This information will assist in program modifications where appropriate for participants.

Do you have any past / present physical limitations that would prevent you from performing a physical activity? If so, please provide details.	YES □ or NO □
Are you able to sit for long periods of times? If no, please provide details.	YES □ or NO □
Are you currently attending rehabilitation support for your injuries? If so, please provide details.	YES □ or NO □
What exercises are you performing to strengthen area of concern? Please provide details.	YES □ or NO □
Are you familiar with R.I.C.E. (Rest, Ice, Compression and Elevation) method for treatment of injury?	YES □ or NO □
Are there any other details that are pertinent that the UAHL program worker needs to be aware of? If so please provide details.	YES □ or NO □
ADDITIONAL NOTES:	

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I, (Please Print Participant Name) _____ affirmed the above information is true, accurate and provide to the best of my ability as this relates to my Pre-Health & Lifestyle Assessment.

Further, I am aware this information is complied as part of the BARRIE NATIVE FRIENDSHIP CENTRE UAHL Program for the sole purpose of program participation, health and safety.

_____ _____

Participant Signature Date:

_____ _____

Parent / Witness Signature Date:

The Urban Aboriginal Healthy Living Program would like to thank you for completing this comprehensive Pre-Health & Lifestyle Assessment.

Please Note:

- *Participants may withdrawal from the program at any time should they desire to do so.*
- *All information provided as part of their Pre-Health & Lifestyle Assessment will assist us in familiarizing you goals, strengths and area of limitations when it come to program participation.*
- *All information is Strictly Confidential and no personal information will be released or shared with for any purpose unless written consent is proved by the participant.*

UNIVERSAL CONSENT
CLIENT DISCOLSURE FORM: FOR THE COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

The Barrie Native Friendship Centre will collect, use and disclose information about you for the following purposes:

- To enable us to contact you
- To establish and maintain communications and contact with you;
- To provide necessary services to you in a variety of areas; office visits, home visits, assessments, accompany you on appointments, meetings, conferences, court appearances, hospitals, treatment centres, healing lodges and other as identified;
- To develop plans of care and practice appropriate case management of your file;
- To provide specific information into data collection system specific to the program(s) which may include information on: age, sex, education, residency, number of children, Aboriginal Status, adoption, residential school, health and others as identified;
- Program reporting requirements, some of which are sent electronically to the OFIFC, covered under Personal Health Information Protection Act (PHIPA)

Personal Health Information Protection Act (PHIPA)
Under the Personal Health Information Protection Act (PHIPA) it is important for you to understand how your personal health information is protected and how it is used.

All workers at the Centre are aware of the sensitive nature of your health information and have received training in the Acts and are sworn to an Oath of Confidentiality. If you are concerned about how your personal health information is collected, used or disclosed, you may file a complaint against the centre or individual, through the Information and Privacy Commissioner of Ontario.

At the Barrie Native Friendship Centre, an assigned Intake Worker or designated Program Worker, will collect your information. From time to time, you may be accessing more than one program or service. This consent form will serve for all Friendship Centre programs you are currently accessing, one program designated as your primary care provider. Your original consent will be kept in that program file.

Universal Client Consent

1. I have reviewed the preceding information and had it explained to me and/or the person who is my legal guardian; or has my power of attorney, where necessary; on how the Barrie Native Friendship Centre, will use my personal information and personal health information.
2. I am also aware of the steps taken by the Centre to protect my information, when it is collected, used or disclosed, as well as how it will be stored and destroyed.
3. I am the parent or guardian of a child (or children) under the age of 18 listed below and do herby give consent on how their information will be collected, used or disclosed, as well as how it will be stored and destroyed.

Name of Child/Children:

_____
_____
_____

4. I agree that the Barrie Native Friendship Centre can collect, use and disclose personal and personal health information about myself, or for _____ as their legal guardian; or I have power of attorney for their health; or they are my children as set out in the above information.

_____ _____
(signature) (print name)

Please circle which applies: Client / Parent / Guardian / Legal Guardian / Power of Attorney

_____ _____
(date) (Signature of Witness)

***Strike out paragraph 3 if the person is not giving consent to their child(ren).

Logged by: