Paths of Courage Healing and Retreat Centre
Residential Healing Program

Program Application

Personal Information:

_____ _____

First Name Last Name

_____ _____

Address (Number, Street, Apt.) City

_____ _____

Province Postal Code

_____ _____

Personal Email Address Birthdate (mm/dd/yyyy)

(___)_____ (___)_____

Day-time Telephone Number Alternate Telephone Number

Can we leave a message? YES NO Can we leave a message? YES NO

(___)_____ (___)_____

Emergency Telephone Number Emergency Contact Name

Have you visited a Hospital Emergency Room in the last year? YES NO

If yes, how many times? _____

How many visits have you made to other mental health agencies in the last year? _____

Part 1: General Information
(To be completed by applicant)

***NOTE* This information is considered private and confidential and will be used only for the purposes of medical assessment for the participation on a course with The Sexual Assault Centre for Quinte and District's Paths of Courage Healing Program.**

EACH PARTICIPANT IS RESPONSIBLE FOR ANY MEDICAL EXPENSES, INCLUDING MEDICAL EVACUATION, AND MUST BE COVERED BY THEIR OWN MEDICAL AND ACCIDENTAL INSURANCE.

Do you have provincial medical coverage? YES NO

Provincial Health Card Number: _____ Province: _____

If the Applicant does not have provincial medical coverage, please indicate private or alternate medical insurance information below and attach a photocopy of your policy information.

Insurance Company: _____ Policy Number: _____

Expiry Date: _____ Group Number: _____

Address: _____ Telephone: (___)_____

Part II: Medical History
To be completed by Applicant. Please use backside of sheet to provide additional details.

_____ _____
First Name Last Name

Give brief statement of your general health:

_____

_____

_____

Height: _____ Weight: _____

Doctor: _____ Doctor Telephone: (___)_____

Do you have any present medical conditions? YES NO

If yes, please describe: _____

Are you taking any medications? YES NO
(If yes, please list in the chart below.)

List medications including name, schedule with dosage amounts (in as much detail as possible please.)

Name of Medication	Condition Being Treated	Dosage Amount	Schedule of Administration

Have you had any surgeries? YES NO

Please give details, including how long ago:

_____

_____

_____

Please list any allergies you may have (ex. bees, seafood, etc.), and the nature and severity of the reaction:

_____

_____

_____

_____

_____

Do you carry an epi-pen for your allergies?

YES NO Details: _____

Do you smoke or use other tobacco products?

YES NO Details: _____

Have you had or do you currently have substance abuse problems (alcohol, drugs, etc)?

YES NO Details: _____

Do you have a history of cardiovascular disease or conditions?

YES NO Details: _____

Do you have a history of high blood pressure or hypertension?

YES NO Details: _____

Do you have asthma?

YES NO Details: _____

Have you had or do you have ulcers or other significant stomach/intestinal problems?

YES NO Details: _____

Do you have any eating disorders: anorexia, bulimia, etc.?

YES NO Details: _____

Do you have hepatitis?

YES NO Details: _____

If yes, please indicate which kind: A B C D

Do you have any bleeding problems or blood disorders?

YES NO Details: _____

Do you have diabetes, hypoglycemia, thyroid or endocrine conditions?

YES NO Details: _____

Do you have chronic bladder infections/problems, difficulty urinating, bedwetting?

YES NO Details: _____

Do you have a seizure disorder?

YES NO Details: _____

Do you suffer from a sleep disorder (ex. sleep apnea)?

YES NO Details: _____

Do you suffer from severe headaches, dizziness, or fainting?

YES NO Details: _____

Have you ever had a brain injury requiring treatment?

YES NO Details: _____

Do you have problems with your neck, back, arms or legs that limit your activity?

YES NO Details: _____

Do you have problems with vision or hearing?

YES NO Details: _____

Do you have chronic skin problems (ex. rashes, sun sensitivity, etc.)?

YES NO Details: _____

Have you had frostbite, a significant reaction to cold, or other circulatory problems?

YES NO Details: _____

Have you ever suffered from heat exhaustion or had significant reactions to heat?

YES NO Details: _____

Does your health prevent you from participating in any physical activities?

YES NO Details: _____

Do you have any communicable diseases?

YES NO Details: _____

For Females: Are you pregnant?

YES NO Details: _____

Do you have a learning disability?

YES NO Details: _____

Have you ever been to a psychiatrist, psychologist, therapist, or counselor?

YES NO Details: _____

If yes,

Are you currently in treatment?

YES NO Details: _____

Have you been under treatment within the last two years?

YES NO Details: _____

Reasons for treatment:

Sexual Abuse	Substance Abuse	Post-Traumatic Stress Disorder
Family Issues	Relationship Issues	Attention Deficit Disorder
Behavioural Disorder	Eating Disorder	Mood/Anxiety Disorder
Psychiatric Hospitalization	Self Harm	Other (social anxiety, etc.):

_____

_____

_____

Name of therapist/counselor so we may contact: _____

Therapist/counselor Telephone: (___)_____

What is your swimming ability? (it is strongly recommended that ALL participants be able to swim at least 100 metres.)

Non-Swimmer Can swim 100m without lifejacket Strong Swimmer

Non-swimmer: are you comfortable (ex. will not panic) in deep water while wearing a lifejacket or PFD?

Please describe in detail what you do routinely to maintain an active lifestyle (mention activities and frequency.)

_____

_____

_____

_____

Following submission of your application, we ask that you review the program description and outline found online at www.sacqd.com, and consider if now is the right time for you to attend the Paths of Courage program.

PATHS OF COURAGE COMMITMENT CONTRACT

What follows is a Commitment Contract between you and the Paths of Courage Healing Program. This means it is a contract between you and the other people in your program. Please read this contract from start to finish and consider each point carefully.

Paths of Courage isn't easy. It isn't meant to be. In fact, some of the satisfaction you'll feel when your program is finished will be because it was difficult. You can expect to be challenged both emotionally and physically. You can also expect to feel strong, confident, independent, and resourceful.

We expect you will complete the course. We are confident you're capable of handling everything a Paths of Courage Healing Program entails. At times, when it gets challenging, you may feel like quitting. Learning how to overcome these feelings is an important part of the program. Your facilitators will be there to encourage and support you.

Alcohol and druges are not permitted:
Any person found with alcohol or drugs on their person or in their possession will be asked to leave the program immediately.

We expect you to be respectful to everyone who is involved in our group.

We expect that you do not become exclusively and/or sexually involved with another member of your group. It is important that you get to know and are able to work with each member of your group. Coupling or cliques of two or three people tend to make others feel left out and create difficult group dynamics. As you will see, the program is a very intense group living experience, the more your group can do to help each member feel safe and valued, the more you will accomplish together.

We expect you to participate. This means taking part the best you can in all aspects of the program. This includes doing your share, co-operating, and listening to others. It also means participating in discussions, and respectfully speaking your mind. We are certain that you have important and thoughtful things to say.

We expect you to take care of yourself. You will learn to make yourself safe and comfortable in a new environment. You will feel more capable if you are careful to eat, drink, and sleep enough. Your facilitators will be there to support you.

We expect you take responsibility for your actions. You will learn how to deal with stressful situations, but part of the learning is sometimes making mistakes. Your facilitators will be there to support you and listen to you throughout the group experience.

We take this contract very seriously. If you feel ready to commit to this contract, print and sign your name and send it back with your document package.

I, _____, am aware of the activities I will be participating in while at PATHS OF COURAGE. This includes group therapy and numerous workshops, physical activities such as kayaking, snowshoeing, hiking, rock climbing, co-operating with my group members, performing my daily tasks, and listening to and respecting the decisions of my facilitators. I also understand that these activities are physically and mentally demanding.

As a participant at PATHS OF COURAGE HEALING AND RETREAT CENTRE, I will make a commitment to complete the entire Paths of Courage Healing Program, and to abstain from the use of drugs and alcohol.

I, _____, have read the above information and am in full understanding of my responsibilities at Paths of Courage Healing Program. I am making a commitment to honour this contract.

_____	_____	_____
Name (please print)	Signature	Date

ACKNOWLEDGEMENT AND ASSUMPTION OF RISK FORM

I understand that during my participation in the PATHS OF COURAGE Healing Program I may be exposed to situations and environmental conditions where the stresses and hazards may be greater or different than those I normally encounter. I understand too, that although PATHS OF COURAGE and THE SEXUAL ASSAULT CENTRE FOR QUINTE AND DISTRICT has taken precautions to provide proper organization, supervision, instruction, and equipment for each activity, circumstances may arise which are not foreseeable or which are beyond the control of The Centre. I acknowledge that the centre cannot guarantee absolute safety. I also understand that I am, in part, responsible for my own safety and I agree to comply with the instructions and directions of the Healing Program staff members.

I fully comprehend and willingly assume the responsibilities and risks, including, but not limited to, any risks which are not foreseeable as part of participating in this program, as outlined in the orientation section of www.saqcd.com.

I have also accepted responsibility to verify that I do not have any physical or psychological problems that would impair my ability to participate in the program or would create undue risk to others or myself who may depend upon me during the program. In this regard, I have completed the PATHS OF COURAGE program Confidential Medical History form and I acknowledge that the centre will rely upon statements as to my medical conditions contained therein and herein.

* I HAVE READ THIS FORM AND I UNDERSTAND AND ACKNOWLEDGE THAT IT IS A CONDITION TO THE APPLICANT BEING ACCEPTED INTO THE PATHS OF COURAGE HEALING PROGRAM THAT I AGREE TO THE ABOVE STATED TERMS OF THIS FORM.

* I ACKNOWLEDGE THAT MISINFORMATION PROVIDED BY ME, THE APPLICANT, WITHIN THIS DOCUMENT MAY RESULT IN MY BEING DISQUALIFIED FROM THE PATHS OF COURAGE PROGRAM.

_____	_____	_____
Applicant's Name (please print)	Applicant's Signature	Date

If the applicant is under 18 years of age:

I (we) consent to the participation by the above-named applicant in the healing program. I (we) make the acknowledgements; assume the risks and responsibilities and release The Sexual Assault Centre for Quinte and District and Paths of Courage in accordance with this Acknowledgement and Assumption of Risk, for and on behalf of myself (ourselves) and the above-named applicant.

_____	_____	_____
Guardian Name (please print)	Guardian Signature	Date