Space4Us Registration Form

Referrer Details

Name of referrer:			
Phone:		**Email:**	
Agency (if relevant):		**Position (if relevant):**	
Relationship to young person:			
Has the young person and parent/ guardian given permission for this referral?	**Yes** ☐	**No** ☐	
Has the young person attended a SPACE4US program before?	**Yes** ☐	**No** ☐	

Young Person Details

Name of young person:					
Address					
Phone:		**Gender:**		**Age:**	
Email:					
Is the young person living with the parent/family member who has a mental illness?	**Yes** ☐	**No** ☐			
Is the young person Aboriginal or Torres Strait Islander (ATSI)?	**Aboriginal** ☐	**Torres Strait Islander** ☐			
Does the young person identify as culturally and linguistically diverse?	**Yes** ☐	**No** ☐			

Parent/Guardian Details

Name of parent/ guardian:		**Relationship to young person:**	
Address:			
Phone:			
Name of family member with the mental illness and relationship to young person (parent, guardian, sibling):			

Emergency Contact Details

Emergency Contact (Other than parent/ guardian)			
Name:		**Relationship to young person:**	
Phone:			

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Brief history of child/ family (relationships between parent/s young person and family, any conflict issues):
Has the young person or their family member been impacted by a significant event due to illness, that facilitators need to be aware of. (e.g., hospitalization, addiction, self-harm, foster care)? If yes, please specify.
Does the young person have any specific needs that facilitators need be aware of? If yes, please specify. (e.g. Behavioural needs, Physical needs, Asthmatic, Allergies, dietary requirements)
Any further information:

Is transport required for the young person to attend?	**Yes ☐**	**No☐**

CONSENT

I _____ being Parent/ Guardian of _____ authorise them to participate in the activities organised by headspace Horsham as outlined in the information provided.

IN CASE OF AN EMERGENCY or in the event of an accident/ illness and where it is not possible at the time to obtain parental consent, I authorise staff to obtain any necessary medical assistance/ treatment.

Verbal consent	Name of Young Person	Name of Parent/Guardian	Signature
Yes ☐ Date _____	_____	_____	_____