lennox & addington INTERVAL HOUSE

# **Child Witness Program** — Application Form

Child's Name: _____ Gender: _____

Custodial Parent: _____ Phone Number: ( ____ ) ____ - _____

Current Address: _____ City: _____ Postal Code: _____

School Attended: _____ Grade: _____

Educational or Special Learning Needs: _____

**Allergies: _____

Siblings Name: _____ Age: _____

Siblings Name: _____ Age: _____

Siblings Name: _____ Age: _____

**There are groups available for mother to participate in while their children are attending their group:**

Are you interested in participating in this program with your child?: ○ Yes ○ No

What is the abusers relationship to the child?: _____

Is the non-custodial parent aware of the referral?: _____

**Are there other agencies involved?:** ○ Yes ○ No

Agency Name: _____ Worker: _____

Agency Name: _____ Worker: _____

Agency Name: _____ Worker: _____

Please describe briefly the family history, current situation and any additional relevant information. Please indicate the types of abuse, history of violence – the frequency and the severity – of what your child may have witnessed:

_____

_____

_____

_____

_____

Please indicate current family issues such as custody and access, child behaviour, ongoing abuse, etc:

_____

_____

_____

_____

# Personal Safety of the Child

If you have reason to believe that the personal safety of the child participating in the program is at risk, please indicate the severity below;

| | |
|---|---|
| ○ High Risk | - Has attempted to locate and snatch the child in the past<br>- May try to snatch again<br>- May be physically abusive towards children and others |
| ○ Moderate Risk | - May try to locate the child<br>- May be verbally abusive towards children or others |
| ○ Low Risk | - Is away of the referral and will not contact |

**CONSENT TO RELEASE INFORMATION**

I consent to the release of information, for the purpose of my child participating in the group, between the agencies I have listed and the community intervention group program. The consent is valid as long as my child is receiving services from the program.

Custodial Parent's Signature

Date

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# Consent for Delivery Services

I authorize the Children's Services Counselor, to provide counseling to my son/ daughter/ward . I understand that she will meet with my child during school hours on an as needed basis.

School Child Attends: _____

Teacher: _____ Grade: _____

Birth Date dd / mm / mm

_____ _____

Custodial Parent's Signature Date

## CONSENT TO RELEASE INFORMATION

I consent to the release of information for the purpose of my child participating in one to one counseling, between the Children's Worker and the staff at the school my child attends.

_____ _____

Custodial Parent's Signature Date

Please return complete form to: Children's Services Outreach Co-coordinator
**Mail:** P.O. Box 113 Napanee ON K7R 3L4 **Drop Off:** 174 Centre St. N Napanee
**FAX #:** 613-354-7311**Phone #:** 613-354-0808
**Email:** laihcw@kingston.net

*Additional information or if you require more space, please use the back of the page.*