Kristen French Child Advocacy Centre Niagara
a safe place to help, heal, end child abuse

Teen Creative

THE foster FESTIVAL
HUMOUR WITH HEART

Screening/Intake Form

Email Completed Form

Please fill in and send back to:

Keegan Langelaan, Youth Outreach Coordinator, Kristen French CACN, 8 Forster St., St. Catharines ON L2N 1Z9

or via email:

youthoutreachcoordinator@kristenfrenchcacn.org

Participants must be between the ages of 12-15 years old & Indigenous.

Please complete all information and questions:

Name of Youth: _____ **Date of Birth:** _____

Name of Caregiver: _____

Contact Information:
Email: _____
Phone: _____
Address: _____

Referred by: _____

What is the youth's understanding of child abuse?

Does the youth feel they are able to share and/or hear others talk about sensitive topics and experiences?

Other service involvement:

How does the youth see themselves benefitting from the group?

Does the youth have any suggestions that they would like to see the group provide?

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Is the parent/guardian and youth able to make the commitment to attend all sessions? *(Please be aware that this is a **closed** group once it begins. Any significant absence will be detrimental to building the peer group dynamic and trust.)*

Abuse History *(While it is understood that participants of this arts program are not required to share any aspect of their experience, participants will be focusing on using creativity as a vehicle to enhance resilience in response to the experience of child abuse and will cover a number of educational topics regarding abuse)***:**

Does the youth have any fears/allergies to animals and/or food products?

Comments/Concerns/Questions:

DATE OF COMPLETION: _____

Should you wish to speak to someone directly please contact:
Keegan Langelaan at 905-937-5435 x 7024 or youthoutreachcoordinator@kristenfrenchcacn.org

By signing this referral form I confirm that all information herein is accurate and that my applicant is aware of and has approved sharing content for the sole purpose of screening participants and that this program is not intended to replace therapeutic practices.

Name: _____ *(Print)*

_____ *(Signature)*
Referral Source (counselor, caregiver/parents, other)

Date: _____

Name: _____ *(Print)*

_____ *(Signature)*
Applicant

Date: _____