

Bloodvein First Nation

PO Bloodvein River, Manitoba. R0C-0J0

Phone Number: 204-395-2796

Bloodvein First Nation

Jordan’s Principle – Intake Checklist

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Intake Conducted By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Information:

|  |  |  |
| --- | --- | --- |
| Surname: | Given Name: | Band No: |
| Address: | Phone No: | Medical No: |
| Date of Birth: | Sex of Child: | Referral By: |

Parent’s/Family Information:

|  |  |
| --- | --- |
| Mother Name: | Father’s Name: |
| Address: | Address: |
| Date of Birth: | Date of Birth: |
| Band No: | Band No: |
| Medical No: | Medical No: |
| Phone No: | Phone No: |

|  |  |
| --- | --- |
| Sibling Name & Age: | Sibling Name & Age: |
| Sibling Name & Age: | Sibling Name & Age: |
| Sibling Name & Age: | Sibling Name & Age: |
| Sibling Name & Age: | Sibling Name & Age: |

Any additional people staying in the home please list below:

Presenting Information:

Please describe any concerns you have about your child’s behaviour or development:

Does your child have any diagnosis from any medical professional?

Do any of the following apply to your child: Yes/No

|  |  |
| --- | --- |
| Difficulty sustaining attention: |  |
| Aggressive towards others or self: |  |
| Easily Frustrated: |  |
| Extreme reaction to noise, smells, touch etc. |  |
| Is fearful towards other or surrounding: |  |
| Trouble waiting on turn/ being impatient: |  |
| Frequent temper tantrums: give examples |  |
| Engages in self-harming: (e.g., banging head on walls) |  |
| Difficult with sudden changes: (schedule change of routine) |  |
| Nervous habits: (shaking of leg) |  |

If you answer yes to any of the above, please describe below:

Does any of the following apply to your child: (Self-Determination) Yes/No

|  |  |
| --- | --- |
| Is your child toilet trained? |  |
| Is your child able to dress themselves? |  |
| Does your child have trouble staying seated up? |  |
| Does your child have difficulty using utensils? |  |
| Does your child have difficulty brushing their teeth & washing face/body? |  |

If you answered no to any the above, please describe:

Does any of the following apply to child? Physical/Communicative Development Yes/No

|  |  |
| --- | --- |
| Does your child struggle with verbal speech? Sounding our words clearly |  |
| Does your child struggle with being able to speak clearly? |  |
| Does your child use sign language to communicate? |  |
| Does your child require technology to communicate? iPad/Computer |  |

If answered yes to any of the above, please describe.

Does any of the following apply to your child? Social/Emotional Development Yes/No

|  |  |
| --- | --- |
| Does your child have trouble making friends? |  |
| Does your child play with toys appropriately or know how to play with toys? |  |
| Is your child able to play independently/quietly by themselves? |  |

If answered yes to any of the above questions, please describe:

Child’s Strengths (areas child excels at, things the child enjoys the most):

Child’s Areas of Needs (areas in which the child may not have age-appropriate):

Child’s Availability (what is the best time of day/week/time to meet):

Parent’s expectations/goals with joining Jordan’s Principle Program:

Additional important information we should know regarding child or family; (Medical/Emotional/Physical):

Emergency Contact Information; (Family or Friend if Needed)



Jordan’s Principle Consent Form

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is giving consent to join the Jordan’s Principle Bloodvein First Nations here in Manitoba for the needs of my child/children physical, mental, emotional or spiritual well-being.

Thank you.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent signature: Parent signature:

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_;