THE REVEREND TOMMY BEARDY MEMORIAL
WEE CHE HE WAYO-GAMIK FAMILY TREATMENT CENTRE
P.O. Box 131, Muskrat Dam, Ontario P0V 3B0
Phone (807) 471-2554 Fax (807) 471-2510

APPLICANT TO READ AND SIGN

Applicant must be signed. If it is not signed. It will not be considered for admission. Upon signing of the application, you are agreeing to the following conditions for your treatment and healing.

- **I will commit and dedicate myself to 6 weeks of my treatment for my alcohol, drug & substance abuse.**
- **I will co operate, participate and follow The Reverend Tommy Beardy Memorial Wee Che He Wayo Gamik Family Treatment Centers guidelines and house rules.**
- **I have been sober and/or drug free for at least 30 days.**
- **I have taken care of all my personal issues and I am ready to start and complete my treatment without distractions.**

All that I have completed in this application is true and to the best of my knowledge. Failure to misinform or comply with the above result in my being dismissed from the program at my own expense upon the discretion of the Executive Director.

Signatures

Applicants Signature	**Date**
Co-Applicants Signature	**Date**
Witness's Signature	**Date**

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MEDICAL FORM FOR THE MOTHER

ADDRESSOGRAPH

Name of applying person: _____

This form to be filled out by a doctor or nurse.

NO PRENATALS will be admitted to the program.
Re:Prenatal
Our community has limited facilities and is geographically isolated, therefore, any pregnant mother cannot be considered for treatment. The program is too intensive and stressful, which we are afraid to the program might harm the unborn baby and mother. The mother should wait at least 3 months after the baby is delivered.

1. **MEDICAL HISTORY**

Does this person have any of the following medical conditions requiring treatment. Please check and describe:

	MEDICAL CONDITIONS	DESCRIPTIONS
	Diabetes	
	Seizure Disorders	
	Chronic Respiratory Conditions (Asthema, COPD)	
	High Blood Pressure	

	MEDICAL CONDITIONS	DESCRIPTIONS
	Heart Conditions	
	Other, please list	

Medication	Dosage

*It is important that the client has a 6 week supply available

Allergies: _____

2. **SPECIAL NEEDS**

Does the client need any special, physical, or psychological needs or disabilities? Yes / No

If yes, please describe:

_____

_____

_____

3. **COMMUNICABLE DISEASE**

	COMMUNICABLE DISEASE	CONDITION AND/OR TREATMENT

*NO PERSON WILL BE ACCEPTED UNTIL TREATMENT HAS BEEN COMPLETED OR THE CONTAGIOUS PERIOD IS FINISHED

4. **TUBERCULOSIS**

Mantoux Date: _____ Result: _____

T.B skin test is required if the client has come into contact with anyone with tuberculosis within the last three months of this medical completion.

Is the client currently on anti-therapy? Yes / No

Does the client have any past or current history of untreated or incomplete therapy? Yes / No

If yes to either, please describe:

_____

_____

_____

5. **IMMUNIZATIONS**

Are immunizations such as TB, Pneumovax and fluzone up to date? Yes / No

If no, vaccine as appropriate:

_____

_____

_____

Describe any significant finding on examination:

_____

_____

_____

Certificate verifies that the Mother is physically able and mentally able to partake in the treatment program for substance abuse within the healing program.

This certifies that _____ is physically able and mentally able to undergo treatment for substance abuse.

Doctor/Nurse Signature: _____

Date of Examination: _____

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MEDICAL FORM FOR THE FATHER

ADDRESSOGRAPH

Name of applying person: _____

This form to be filled out by a doctor or nurse.

1. **MEDICAL HISTORY**

Does this person have any of the following medical conditions requiring treatment. Please check and describe:

	MEDICAL CONDITIONS	DESCRIPTIONS
	Diabetes	
	Seizure Disorders	
	Chronic Respiratory Conditions (Asthema, COPD)	
	High Blood Pressure	
	Heart Conditions	
	Other, please list	

Medication	Dosage

*It is important that the client has a 6 week supply available

Allergies: _____

2. **SPECIAL NEEDS**

Does the client need any special, physical, or psychological needs or disabilities? Yes / No

If yes, please describe:

_____

_____

_____

3. **COMMUNICABLE DISEASE**

	COMMUNICABLE DISEASE	CONDITION AND/OR TREATMENT

*NO PERSON WILL BE ACCEPTED UNTIL TREATMENT HAS BEEN COMPLETED OR THE CONTAGIOUS PERIOD IS FINISHED

4. **TUBERCULOSIS**

Mantoux Date: _____ Result: _____

T.B skin test is required if the client has come into contact with anyone with tuberculosis within the last three months of this medical completion.

Is the client currently on anti-therapy? Yes / No

Does the client have any past or current history of untreated or incomplete therapy? Yes / No

If yes to either, please describe:

_____

_____

_____

5. IMMUNIZATIONS

Are immunizations such as TB, Pneumovax and fluzone up to date? Yes / No

If no, vaccine as appropriate:

_____

_____

_____

Describe any significant finding on examination:

_____

_____

_____

Certificate verifies that the Father is physically able and mentally able to partake in the treatment program for substance abuse within the healing program.

This certifies that _____ is physically able and mentally able to undergo treatment for substance abuse.

Doctor/Nurse Signature: _____

Date of Examination: _____

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MEDICAL FORM FOR CHILD

ADDRESSOGRAPH

Name of child: _____

This form to be filled out by a doctor or nurse.

Please copies as needed for children.

1. **MEDICAL HISTORY**

Does this person have any of the following medical conditions requiring treatment. Please check and describe:

	MEDICAL CONDITIONS	DESCRIPTIONS
	Diabetes	
	Seizure Disorders	
	Chronic Respiratory Conditions (Asthema, COPD)	
	High Blood Pressure	
	Heart Conditions	
	Other, please list	

Medication	Dosage

*It is important that the client has a 6 week supply available

Allergies: _____

2. **SPECIAL NEEDS**

Does the client need any special, physical, or psychological needs or disabilities? Yes / No

If yes, please describe:

_____

_____

_____

3. **COMMUNICABLE DISEASE**

	COMMUNICABLE DISEASE	CONDITION AND/OR TREATMENT

*NO PERSON WILL BE ACCEPTED UNTIL TREATMENT HAS BEEN COMPLETED OR THE CONTAGIOUS PERIOD IS FINISHED

4. **TUBERCULOSIS**

Mantoux Date: _____ Result: _____

T.B skin test is required if the client has come into contact with anyone with tuberculosis within the last three months of this medical completion.

Is the client currently on anti-therapy? Yes / No

Does the client have any past or current history of untreated or incomplete therapy? Yes / No

If yes to either, please describe:

_____

_____

_____

5. IMMUNIZATIONS

Are immunizations such as TB, Pneumovax and fluzone up to date? Yes / No

If no, vaccine as appropriate:

_____

_____

_____

Describe any significant finding on examination:

_____

_____

_____

Certificate verifies that the Child is physically able and mentally able to partake in the treatment program for substance abuse within the healing program.

This certifies that _____ is physically able and mentally able to undergo treatment for substance abuse.

Doctor/Nurse Signature: _____

Date of Examination: _____