Registration Form

Becoming the Boss of My Worries

Spring 2016 session

Child's Name: _____
First Name Last Name

Child's date of birth: _____ Child's age: _____
Month / Day / Year Years / Months

Address: _____

Parent's name (1): _____
First Name Last Name

Email _____

Phone # (day) _____ (home) _____ (cell) _____

Parent's name (2): _____
First Name Last Name

Email _____

Phone # (day) _____ (home) _____ (cell) _____

IN CASE OF AN EMERGENCY please contact: (Same as above ☐) OR

Name: _____ Relationship: _____ Phone: _____

Does your child have dietary restrictions and/or allergies? Yes ☐ No ☐

If yes, please specify: _____

Does your child have any special needs? Yes ☐ No ☐

If yes, please describe: _____

_____

_____

_____

As a parent who knows their child the best, please describe your areas of concern for your child in relation to their anxiety, as well as the skills and/or goal areas you would you like to see your child develop and/or work on.

Please be reassured that all information will be kept CONFIDENTIAL, and is intended to assist us in understanding your child and his/her needs.

_____

_____

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_____

Has your child participated in a group/ therapy before?
(If so, please list the group name/service provider)

_____

_____

_____

I consent and give permission for my child _____ to participate in the
Print child's name

Becoming the Boss of My Worries group program.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Date

Parents will be asked to complete a phone interview with one of the group facilitators in order to ensure an appropriate fit for this group prior to acceptance into the program.