bgc Cornwall/SDG

Member Safety Plan

Member Name: _____ **DOB**:_____ **BGC Program:** _____
School: _____ **Grade**:_____ **Gender:** _____

Diagnosis	
Medical Information	
Injurious Behaviours (hitting, kicking, biting)	
Risk Factors/Triggers	
Strategies for Deescalating Behaviours	
Child's Strengths	

Does your Child:		**If yes, please provide details**
Have EA support in school?	Yes / No	
Need assistance with toileting?	Yes / No	
Need assistance with Recreation or Educational activities?	Yes / No	
Leave/run from the area when upset?	Yes / No	
Use observational cues (visual schedule, timers)	Yes / No	
require use of items for comfort (teddy bears, stress balls, toys)?	Yes / No	

Additional Information:	

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*You may be contacted to pick your child up any time during programming hours.

Person/Staff completing this form: _____

---------- **OFFICE USE ONLY** ----------

Parent/Guardian Consultation (To be completed after reviewing safety plan):

Members Name		
Parent/Guardian	Name:	Phone #:
Date of Consultation		
Referring Agency		
Referring Agency Worker	Name:	Phone #:

☐ The parent/guardian has been consulted and I give my consent to attend our _____ without further instructions.
Name of Program

☐ Currently, this child is not a fit for our_____.
Name of Program

☐ The parent/guardian has been consulted and this child can attend our _____on a trial basis.
Name of Program

Time frame of trial basis: _____ Date of follow-up: _____

Parent/Guardian signature _____ *Date*: _____

Program Manager/designate signature: _____ *Date:* _____