

REGISTRATION FORM

The Kinship CARE Project

A partnership between Secure Start® & the Department for
Child Protection



NAME: _____

ADDRESS: _____

PHONE: _____

EMAIL: _____

SPECIAL DIETARY REQUIREMENTS: _____

KINSHIP CARE SUPPORT WORKER: _____

OFFICE SUPPORTING THE CHILD IN YOUR CARE: _____

NUMBER OF CHILDREN YOU ARE CARING FOR: _____

LENGTH OF TIME YOU HAVE BEEN A KINSHIP CARER: _____

DO YOU IDENTIFY AS ABORIGINAL OR TORRES STRAIT ISLANDER? _____

WHAT TRAINING HAVE YOU RECEIVED WITH REGARDS TO YOUR CARING ROLE:

WHAT BEHAVIOUR(S) DOES THE CHILD YOU CARE FOR PRESENT WITH THAT CONCERNS YOU THE MOST?

HOW MUCH DO YOU KNOW ABOUT THERAPEUTIC CARE? Please tick

- Nothing
 A bit
 Quite a lot

WHAT DO YOU HOPE TO GET OUT OF THE TRAINING?

Eyes are mirrors for a child's soul. What do children see in your eyes?

PLEASE RETURN THIS FORM TO georgina@securestart.com.au

Registrant numbers are limited. However, if there are insufficient numbers Secure Start reserves the right to cancel the workshop and reschedule.