PRAIRIE MOUNTAIN HEALTH

Organization Coordinator ☐

# UNIFIED REFERRAL AND INTAKE SYSTEM (URIS) GROUP B APPLICATION (a)

## Review application, complete and sign.

In accordance with Section 15 of *The Personal Health Information Act* (PHIA), the purpose of this form is to identify the child's health care intervention(s) and apply for URIS Group B support which includes the development of a health care plan and training of community program staff by a registered nurse. URIS is a partnership of health, education and family services. If you have questions about the information requested on this form, you may contact the community program.

## Section I – Community program information (to be completed by the community program)

| **Type of community program *(please √)*** | **Community Program:** Souris Cooperative Early Learning Programs<br>Contact person: Tara Mills | **Where service will be provided:**<br>☒ Same as on left<br>Contact person: |
|---|---|---|
| ☐ School<br>☒ Licensed child care<br>☐ Respite<br>☐ Recreation program | Phone: 204-483-2535 Fax: | Phone: Fax: |
| | Email: selc@wcgwave.ca | Email: |
| | Mailing address : Box 1004<br>Street: 82 1st St S<br>City/Town: Souris<br>Postal Code: R0K 2C0 | Mailing address : Box 1004<br>Street: 82 1st St S<br>City/Town: Souris<br>Postal Code: R0K 2C0 |

**Section II - Child information *(legal name)***

| **Last Name** | **First Name** | **Birthdate** |
|---|---|---|
| | | *Month (print) D D Y Y Y Y* |

| **Also Known As** | **Age:** | **Grade:** | **Gender:** |
|---|---|---|---|
| | | | ☐ **M** ☐ **F** |

**Does your child ride the bus?** ☐ **YES** ☐ **NO** **Bus Driver's Name or Bus Number:** _____

**Does your child have any of the following listed health concerns?** ☐ **YES** ☐ **NO**

- If you have answered **NO**, please sign below and return this form to the school.
- If you have answered **YES**, please complete the entire form and return to the school.

| *Parent/ Legal Guardian NAME* | *Parent/Legal Guardian SIGNATURE* | *DATE (MON/DD/YYYY)* |
|---|---|---|
| | | |

*Please check (√) all health care conditions for which the child requires an intervention during attendance at the community program.*

☐ **YES** ☐ **NO** **Life-threatening allergy (and child is prescribed an Auto-injector [Epi-Pen®/ Twinject®/ Allerject®])**
- ☐ **YES** ☐ **NO** Does the child bring an auto-injector to the community program?

☐ **YES** ☐ **NO** **Asthma (administration of medication by inhalation)**

***IF ASTHMA IS THE ONLY HEALTH CONDITION, PLEASE SIGN AND COMPLETE THE ATTACHED INDIVIDUAL HEALTH CARE PLAN***
- ☐ **YES** ☐ **NO** Does the child bring asthma medication (puffer) to the community program?
- ☐ **YES** ☐ **NO** Can the child take the asthma medication (puffer) on his/her own?

☐ **YES** ☐ **NO** **Seizure disorder What type of seizure(s) does the child have?** _____
- ☐ **YES** ☐ **NO** Does the child require administration of rescue medication? ☐**Lorazepam** ☐**Midazolam**
- ☐ **YES** ☐ **NO** Does the child require the use of a vagal nerve stimulator (wand)?

☐ **YES** ☐ **NO** **Diabetes What type of diabetes does the child have?** ☐ **Type 1** ☐ **Type 2**
- ☐ **YES** ☐ **NO** Does the child require blood glucose monitoring at the community program?
- ☐ **YES** ☐ **NO** Does the child require assistance with blood glucose monitoring?
- ☐ **YES** ☐ **NO** Does the child have low blood glucose emergencies that require a response?

| | | |
|---|---|---|
| ☐ **YES** ☐ **NO** | **Ostomy Care** | |
| | ☐ **YES** ☐ **NO** | Does the child have an ostomy/stoma? |
| | ☐ **YES** ☐ **NO** | Does the child require the ostomy pouch to be emptied at the community program? |
| | ☐ **YES** ☐ **NO** | Does the child require the established appliance to be changed at the community program? |
| | ☐ **YES** ☐ **NO** | Does the child require assistance with ostomy care at the community program? |
| ☐ **YES** ☐ **NO** | **Gastrostomy Care** | |
| | ☐ **YES** ☐ **NO** | Does the child have a gastrostomy tube? Type of tube: _____ |
| | ☐ **YES** ☐ **NO** | Does the child require gastrostomy tube feeding at the community program? |
| | ☐ **YES** ☐ **NO** | Does the child require administration of medication via the gastrostomy tube at the program? |
| ☐ **YES** ☐ **NO** | **Clean Intermittent Catheterization (IMC)** | |
| | ☐ **YES** ☐ **NO** | Does the child require IMC? |
| | ☐ **YES** ☐ **NO** | Does the child require assistance with IMC at the community program? |
| ☐ **YES** ☐ **NO** | **Pre-set Oxygen** | |
| | ☐ **YES** ☐ **NO** | Does the child require pre-set oxygen at the community program? |
| | ☐ **YES** ☐ **NO** | Does the child bring oxygen equipment to the community program? |
| ☐ **YES** ☐ **NO** | **Suctioning (oral and/or nasal)** | |
| | ☐ **YES** ☐ **NO** | Does the child require oral and/or nasal suctioning at the community program? |
| | ☐ **YES** ☐ **NO** | Does the child bring suctioning equipment to the community program? |
| ☐ **YES** ☐ **NO** | **Cardiac Condition (where the child requires a specialized emergency response at the community program).** | |
| | What type of cardiac condition has the child been diagnosed with? _____ | |
| ☐ **YES** ☐ **NO** | **Bleeding Disorder (e.g., von Willebrand disease, hemophilia)** | |
| | What type of bleeding disorder has the child been diagnosed with? _____ | |
| ☐ **YES** ☐ **NO** | **Steroid Dependence (e.g., congenital adrenal hyperplasia, hypopituitarism, Addison's disease)** | |
| | What type of steroid dependence has the child been diagnosed with? _____ | |
| ☐ **YES** ☐ **NO** | **Osteogenesis Imperfecta (brittle bone disease)** What type? _____ | |

## Section III - Authorization for the Release of Medical Information

I authorize the Community Program, the Unified Referral and Intake System Provincial Office, and the nursing provider serving the community program, all of whom may be providing services and/or supports to my child, to exchange and release medical information specific to the health care interventions identified above and consult with my child's physician(s), if necessary, for the purpose of developing and implementing an Individual Health Care Plan/Emergency Response Plan and training community program staff for _____

(***Child's Name***).

I also authorize the Unified Referral and Intake System Provincial Office to include my child's information in a provincial database which will only be used for the purposes of program planning, service coordination and service delivery. This database may be updated to reflect changing needs and services. I understand that my child's personal and personal health information will be kept confidential and protected in accordance with *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA).

I understand that any other collection, use or disclosure of personal information or personal health information about my child will not be permitted without my consent, unless authorized under FIPPA or PHIA.

Consent will be reviewed with me annually. I understand that as the parent/legal guardian I may amend or revoke this consent at any time with a written request to the community program.

If I have any questions about the use of the information provided on this form, I may contact the community program directly.

_____ _____ _____

*Parent/ Legal Guardian NAME* *Parent/Legal Guardian SIGNATURE* *DATE (MON/DD/YYYY)*

Mailing Address: _____ City/Town: _____ Postal Code: _____

Work/Daytime Phone: _____ Cell Phone: _____ Home Phone: _____