Review application, complete & sign.

SSC / Child Care Provider ☐

Unified Referral and Intake System (URIS) Group B Application

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. 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 √)	
❑ School ❑ Licensed child care ❑ Respite ❑ Recreation program	**Name of community program:**
	Contact person:
	Phone: **Fax:**
	Email:
	Address (location where service is to be delivered): **Street:** **P.O Box:** **City/Town:** **Postal Code:**

Section II - Child information *(legal name)*

Last Name **First Name** **Birthdate**

Month (print) D D Y Y Y Y

Also Known As

Gender: ☐ **M** ☐ **F**

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

Did a URIS Nurse develop a Health Care Plan Last Year? ☐ **YES** ☐ **NO**

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

IF YOU ANSWERED NO TO BOTH QUESTIONS, YOU ARE DONE. PLEASE SIGN AND RETURN TO COMMUNITY PROGRAM.

_____ _____ _____

Parent/ Legal Guardian NAME *Parent/Legal Guardian SIGNATURE* *DATE*

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®])**

☐ **YES** ☐ **NO** Does the child bring an EpiPen to the community program?

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

IF ASTHMA IS THE ONLY HEALTH CONDITION, PLEASE 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** Has the child been hospitalized in the past year?

☐ **YES** ☐ **NO** **Seizure disorder** What type of seizure(s) does the child have? _____

☐ **YES** ☐ **NO** Does the child require administration of rescue medication (e.g., sublingual lorazepam)?

☐ **YES** ☐ **NO** **Diabetes**

☐ **Type 1** ☐ **Type 2** What type of diabetes does the child have?

☐ **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 sugar emergencies that require a response?

☐ **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? _____

☐ **YES** ☐ **NO** **Gastrostomy Care**

- ☐ **YES** ☐ **NO** Does the child have a gastrostomy 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 community program?

☐ **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** **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?

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. I can view the Assiniboine Regional Health Authority's ***Rights and Responsibilities*** on the internet at www.assiniboine-rha.ca or by calling 204-476-7560.

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 (Please Print) Parent/ Legal Guardian Signature Date

_____ _____ _____ _____
Mailing Address Town Postal Code Email Address

_____ _____ _____
Home Telephone Number Cell Phone Number Work Phone Number