PRAIRIE MOUNTAIN HEALTH

Community Program Representative ☐

UNIFIED REFERRAL AND INTAKE SYSTEM (URIS) GROUP B APPLICATION

Review application, complete and sign in ink

The purpose of this form is to identify the child's specific health care and if applicable, apply for URIS Group B support which may include the development of a health care plan and training of community program staff by a registered nurse. URIS is a partnership of Education and Early Childhood Learning, Health, Senior and Long-term Care and Families. If you have questions about the information requested on this form, you may contact the community program.

Section I – To be completed by the community program

Type of community program *(please √)*	**Community Program Name:**
❑ School ❑ Licensed child care ❑ Respite ❑ Recreation program ❑ Other:_____	Contact person: Phone: Fax: Email: Mailing address: Street address: City/Town: Postal Code:

Section II - Child information - to be completed by parent

Last Name | **First Name** | **Birthdate** (*Y Y Y Y M M M D D*)

Preferred Name (Alias) | **Age** | **Grade** | **Gender** ☐ M ☐ F ☐ Other

➢ Please check (√) all health care conditions for which the child requires an intervention during attendance at the community program. Return the completed form to the community program.

☐ YES ☐ NO	**Life-threatening allergy and child is prescribed an injector (e.g. Epi-Pen®/ Allerject®)**
☐ YES ☐ NO	Does the child bring an injector to the community program?
☐ YES ☐ NO	**Asthma (administration of medication by inhalation)**
☐ YES ☐ NO	Does the child bring reliever medication (puffer) to the community program?
☐ YES ☐ NO	Does your child know **when** to take their reliever medication (puffer) e.g. can recognize signs of asthma?
☐ YES ☐ NO	Can your child take their reliever medication (puffer) **on their 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	**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	**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	**Ostomy Care**
	☐ 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 (CIC)**
	☐ YES ☐ NO Does the child require CIC?
	☐ YES ☐ NO Does the child require assistance with CIC 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	**Bleeding Disorder (e.g., von Willebrand disease, hemophilia)**
	What type of bleeding disorder has the child been diagnosed with? _____
☐ YES ☐ NO	**Endocrine Conditions (e.g. steroid dependence, congenital adrenal hyperplasia, hypopituitarism, Addison's disease)**
	What type of endocrine condition has the child been diagnosed with? _____
☐ YES ☐ NO	**Osteogenesis Imperfecta (brittle bone disease)** What type? _____

Section III - Authorization for the Release of Medical Information

In accordance with *The Personal Health Information Act* (PHIA),I authorize the Community Program, the Unified Referral and Intake System Provincial Office, the nursing provider serving the community program, and my child's health care provider(s), 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 for the purpose of developing and implementing an Individual Health Care Plan/Emergency Response Plan and training community program staff for:

Child's Name: _____ ***Child's PHIN:*** _____

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.

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.

_____	_____	_____
NAME (PRINT) *Parent/ Legal Guardian*	***SIGNATURE*** *Parent/Legal Guardian*	*DATE (YYYY/MMM/DD)*

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

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

Email: _____