

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

Review application, complete and sign in ink – to be completed **ANNUALLY**.

The purpose of this form is to identify the child's specific health care and if applicable, 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 – To be completed by the community program

Type of community program (please ✓) <input type="checkbox"/> School <input type="checkbox"/> Licensed child care <input type="checkbox"/> Respite <input type="checkbox"/> Recreation program <input type="checkbox"/> Other: _____ _____	Community Program Name: _____	Location of Service: <input type="checkbox"/> Same as on left
	Contact person: _____	Contact person: _____
	Phone: _____ Fax: _____	Phone: _____ Fax: _____
	Email: _____	Email: _____
	Mailing address: Street address: _____ City/Town: _____ Postal Code: _____	Mailing address: Street address: _____ City/Town: _____ Postal Code: _____

Section II - Child information - to be completed by parent

Last Name	First Name	Birthdate
		Month (print) D D Y Y Y Y
Preferred Name (Alias)	Age	Grade
		Gender
		<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other

Does your child ride the bus? YES NO

Does your child have any of the following listed health concerns? YES NO (check (✓) one)

➤ If you have answered **NO**, please sign here and return this form to the community program.

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

- If you have answered **YES**, please complete the remainder of the form **including Section III**.
- 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.

<input type="checkbox"/> YES <input type="checkbox"/> NO	Life-threatening allergy and child is prescribed an injector (e.g. Epi-Pen®/ Taro Epinephrine®/ Allerject®)	<input type="checkbox"/> YES <input type="checkbox"/> NO Does the child bring an injector to the community program?
<input type="checkbox"/> YES <input type="checkbox"/> NO	Asthma (administration of medication by inhalation)	<input type="checkbox"/> YES <input type="checkbox"/> NO Does the child bring reliever medication (puffer) to the community program? <input type="checkbox"/> YES <input type="checkbox"/> NO Does your child know when to take their reliever medication (puffer) e.g. can recognize signs of asthma? <input type="checkbox"/> YES <input type="checkbox"/> NO Can your child take their reliever medication (puffer) on their own ? IF NO , describe what your child needs help with: _____
<input type="checkbox"/> YES <input type="checkbox"/> NO	Seizure disorder What type of seizure(s) does the child have? _____	<input type="checkbox"/> YES <input type="checkbox"/> NO Does the child require administration of rescue medication? <input type="checkbox"/> Lorazepam <input type="checkbox"/> Midazolam <input type="checkbox"/> YES <input type="checkbox"/> NO Does the child require the use of a vagal nerve stimulator (wand)?
<input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes What type of diabetes does the child have? <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	<input type="checkbox"/> YES <input type="checkbox"/> NO Does the child require blood glucose monitoring at the community program? <input type="checkbox"/> YES <input type="checkbox"/> NO Does the child require assistance with blood glucose monitoring? <input type="checkbox"/> YES <input type="checkbox"/> NO Does the child have low blood glucose emergencies that require a response?

<input type="checkbox"/> YES	<input type="checkbox"/> NO	Ostomy Care	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child have an ostomy/stoma?
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child require the ostomy pouch to be emptied at the community program?
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child require the established appliance to be changed at the community program?
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child require assistance with ostomy care at the community program?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Gastrostomy Care	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child have a gastrostomy tube? Type of tube: _____
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child require gastrostomy tube feeding at the community program?
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child require administration of medication via the gastrostomy tube at the program?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Clean Intermittent Catheterization (CIC)	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child require CIC?
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child require assistance with CIC at the community program?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Pre-set Oxygen	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child require pre-set oxygen at the community program?
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child bring oxygen equipment to the community program?
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Suctioning (oral and/or nasal)	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child require oral and/or nasal suctioning at the community program?
		<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the child bring suctioning equipment to the community program?
<input type="checkbox"/> YES	<input type="checkbox"/> 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? _____
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Bleeding Disorder (e.g., von Willebrand disease, hemophilia)	
			What type of bleeding disorder has the child been diagnosed with? _____
<input type="checkbox"/> YES	<input type="checkbox"/> NO	Endocrine Conditions (e.g. steroid dependence, congenital adrenal hyperplasia, hypopituitarism, Addison's disease)	
			What type of steroid dependence has the child been diagnosed with? _____
<input type="checkbox"/> YES	<input type="checkbox"/> 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, 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 health care provider, 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: _____ **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.

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.

NAME (PRINT) Parent/ Legal Guardian	SIGNATURE Parent/Legal Guardian	DATE (MMM/DD/YYYY)
Mailing Address: _____	City/Town: _____	Postal Code: _____
Work/Daytime Phone: _____	Cell Phone: _____	Home Phone: _____
Email: _____		