PRAIRIE MOUNTAIN HEALTH

Community Program Representative ☐

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

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 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 √)*	Community Program Name:	Location of Service: ☐ Same as on left
❑ School ❑ Licensed child care ❑ Respite ❑ Recreation program ❑ Other: _____	Contact person: Phone: Fax: Email: Mailing address: Street address: City/Town: Postal Code:	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

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 (YYYY/MMM/DD)*

➢ 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.

☐ YES ☐ NO	**Life-threatening allergy and child is prescribed an injector (e.g. Epi-Pen®/ Taro Epinephrine®/ 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**? **IF NO**, describe what your child needs help with: _____
☐ 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 (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	**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	**Endocrine Conditions (e.g. steroid dependence, 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

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 (YYYY/MMM/DD)*

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

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

Email: _____

Manitoba

ANAPHYLAXIS HEALTH CARE PLAN

Child name:		**Birth date:**
Community program name:		
Parent/guardian name:		
Home #:	**Cell #:**	**Work #:**
Parent/guardian name:		
Home #:	**Cell #:**	**Work #:**
Alternate emergency contact name:		
Home #:	**Cell #:**	**Work #:**
Allergist:		**Phone #:**
Pediatrician/Family doctor:		**Phone #:**

Life-threatening allergies (i.e. allergies that epinephrine auto-injector is prescribed for):

Other allergies (non life-threatening):

Does child wear MedicAlert™ identification for life-threatening allergy(s)? ☐ **YES** ☐ **NO**

Epinephrine auto-injector information

Type

- ☐ EpiPen® 0.15 mg (green)
- ☐ EpiPen® 0.3 mg (yellow)
- ☐ Allerject® 0.15 mg (blue)
- ☐ Allerject® 0.3 mg (orange)

Location - It is recommended that the child carries the epinephrine auto-injector at all times.

- ☐ Fanny pack
- ☐ Back pack
- ☐ Purse
- ☐ Other – Describe _____

Child has a 2nd (back-up) auto-injector available at the community program.

- ☐ YES Location _____
- ☐ NO

Other information about my child's life threatening allergy that community program should know.

This Health Care Plan should accompany the child on excursions outside the facility.

Manitoba

ANAPHYLAXIS HEALTH CARE PLAN

Name:	**Birth date:**
IF YOU SEE THIS →	**DO THIS**

If ANY combination of the following signs is present and there is reason to suspect anaphylaxis:

Face
- Red, watering eyes
- Runny nose
- Redness and swelling of face, lips and tongue
- Hives (red, raised & itchy rash)

A**irway**
- A sensation of throat tightness
- Hoarseness or other change of voice
- Difficulty swallowing
- Difficulty breathing
- Coughing
- Wheezing
- Drooling

Stomach
- Severe vomiting
- Severe diarrhea
- Severe cramps

Total body
- Hives (red, raised & itchy rash)
- Feeling a "sense of doom"
- Change in behavior
- Pale or bluish skin
- Dizziness
- Fainting
- Loss of consciousness

1. Inject the epinephrine auto-injector in the outer middle thigh.
   a) Secure the child`s leg. The child should be sitting or lying down in a position of comfort.
   b) Identify the injection area on the outer middle thigh.
   c) Hold the epinephrine auto-injector correctly.
   d) Remove the safety cap by pulling it straight off.
   e) Firmly press the tip into the outer middle thigh at a 90º angle until you hear or feel a click. Hold in place to ensure all the medication is injected.
   f) Discard the used epinephrine auto-injector following the community program's policy for disposal of sharps or give to EMS personnel.
2. Activate 911/EMS.
   Activating 911/EMS should be done simultaneously with injecting the epinephrine auto-injector by delegating the task to a responsible person.
3. Notify parent/guardian.
4. A second dose of epinephrine may be administered within 5-15 minutes after the first dose is given IF symptoms have not improved.
5. Stay with child until EMS personnel arrive.
   Prevent the child from sitting up or standing quickly as this may cause a dangerous drop in blood pressure.

Antihistamines are NOT used in managing life-threatening allergies in community program settings.

Risk reduction strategies

Avoidance of allergens is the only way to prevent an anaphylactic reaction. Although it is not possible to achieve complete avoidance of allergens in community program settings, it is important to reduce exposure to life-threatening allergen(s). Contact the community program if you have any questions about the risk reduction strategies that are implemented in their facility. School division policy may be found on their website.

I have reviewed this health care plan and provide consent to this plan on behalf of my child.

Parent/guardian signature: _____ **Date:** _____

I have reviewed this health care plan to ensure it provides the community program with required information.

Nurse signature: _____ **Date:** _____

Documentation

Manitoba

ASTHMA HEALTH CARE PLAN

Child name:		**Birth date:**
Community program name:		
Parent/guardian name:		
Home Ph#:	**Cell #:**	**Work Ph#:**
Parent/guardian name:		
Home Ph#:	**Cell #:**	**Work Ph#:**
Alternate emergency contact name:		
Home Ph#:	**Cell #:**	**Work Ph#:**
Allergist:		**Phone #:**
Pediatrician/Family doctor:		**Phone #:**
Known allergies:		
Does child wear MedicAlert™ identification for asthma?	☐ **YES** ☐ **NO**	

TRIGGERS - List items that most commonly trigger your child's asthma.

RELIEVER MEDICATION (or bronchodilators) provides fast temporary relief from asthma symptoms. It is recommended that Reliever medication is carried with the child so it is available if an asthma episode occurs.

What Reliever medication has been prescribed for your child? (CHECK ONE)	☐ Salbutamol (e.g. Ventolin®, Airomir®) ☐ Symbicort®	☐ Other _____
How many puffs of Reliever medication are prescribed for an asthma episode? (CHECK ONE)	☐ 1 puff ☐ 2 puffs	☐ 1 or 2 puffs ☐ other _____
Where does your child carry his/her Reliever medication? (CHECK ONE)	☐ fanny pack ☐ backpack	☐ purse ☐ other _____
Does your child know when to take their Reliever medication?	☐ Yes ☐ No	**Can your child take their Reliever medication on their own?** ☐ Yes ☐ No

CIRCLE the type of medication device your child uses for Reliever medication.


Metered dose inhaler (MDI)


MDI & spacer with mouthpiece


MDI & spacer with mask


Turbuhaler®


Diskus®

The Health Care Plan should accompany the child on excursions outside the facility.

Manitoba

ASTHMA HEALTH CARE PLAN

Name:	**Birth date:**

IF YOU SEE THIS:	**DO THIS:**
Symptoms of asthma • Coughing • Wheezing • Chest tightness • Shortness of breath • Increase in rate of breathing while at rest	1. Remove the child from triggers of asthma. 2. Have the child sit down. 3. Ensure the child takes Reliever medication (usually blue cap or bottom). 4. Encourage slow deep breathing. 5. Monitor the child for improvement of asthma symptoms. 6. If Reliever medication has been given and asthma symptoms do not improve in 5-10 minutes, contact parent/guardian. • *Reliever medication can be repeated once at this time. If the child is not well enough to remain at the community program, the parent/guardian should come and pick them up.* 7. If any of the emergency situations occur (see list below), call 911/EMS.
Emergency situations • Skin pulling in under the ribs • Skin being sucked in at the ribs or throat • Greyish/bluish color in lips and nail beds • Inability to speak in full sentences • Shoulders held high, tight neck muscles • Cannot stop coughing • Difficulty walking	1. Activate 911/EMS. *Delegate this task to another person. Do not leave the child alone.* 2. Continue to give Reliever medication as prescribed every five minutes. 3. Notify the child's parent/guardian. 4. Stay with the child until EMS personnel arrives.

Signs that asthma is not controlled

If staff becomes aware of any of the following situations, they should inform the child's parent/guardian.

- Asthma symptoms prevent the child from performing normal activities.
- The child is frequently coughing, short of breath or wheezing.
- The child is using Reliever medication more than 3 times per week for asthma symptoms.

I have reviewed this health care plan and provide consent to this plan on behalf of my child.

Parent/guardian signature: _____ **Date:** _____

I have reviewed this health care plan to ensure it provides the community program with required information.

Nurse signature: _____ **Date:** _____

Documentation

☐ **Instruction sheet for medication device attached**