MARGARET WARD
Superintendent/CEO

TYLER MORAN
Assistant Superintendent

AL LEIMAN
Secretary-Treasurer

"Preparing Today's Learner for Tomorrow"

Dear Parent/Guardian:

The Unified Referral and Intake System (URIS) is a joint initiative of the provincial departments of Health, Education and Family Services. It provides support for children with specific health care needs when they are attending community programs including schools, licensed child care facilities and respite. For children with health care need(s) listed below, URIS support includes the development of a written health care plan and training of community program staff by a registered nurse.

- Anaphylaxis
- Asthma
- Bleeding disorder
- Cardiac condition
- Diabetes
- Seizure disorder
- Steroid dependent condition
- Osteogenesis imperfecta
- Gastrostomy care
- Catheterization
- Ostomy care
- Pre-set oxygen
- Oral or nasal suctioning

PLEASE COMPLETE THE BOX BELOW AND RETURN THE FORM(S) TO THE SCHOOL.

□ My child _____ is diagnosed with one or more of the health care needs listed above. I have completed the URIS Group B Application attached and provided it to the school.

□ My child _____ is NOT diagnosed with any of the health care needs listed above.

_____ _____

Parent/Guardian signature Date

Sincerely,

Michelle Procter
Student Services Administrator

192 – 2nd Ave. N. (PTH 67) Stonewall, Manitoba R0C 2Z0
Telephone: (204) 467-5100 Fax: (204) 467-8334 Website: www.isd21.mb.ca

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

Section II - Child information

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

month (print) D D Y Y Y Y

Also Known As

Bus Student -Yes or No

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

❑ **Life-threatening allergy (and child is prescribed an EpiPen)**

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

❑ **Asthma (administration of medication by inhalation)**

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? _____

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

❑ **Diabetes**

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

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? _____

❑ **Bleeding Disorder** (e.g., von Willebrand disease, hemophilia)

What type of bleeding disorder has the child been diagnosed with? _____

❑ **Steroid Dependence** (e.g., congenital adrenal hyperplasia, hypopituitarism, Addison's disease)

What type of steroid dependence has the child been diagnosed with? _____

❑ **Osteogenesis Imperfecta (brittle bone disease)**

❑ **Gastrostomy Feeding Care**

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**

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)**

Does the child require assistance with IMC at the community program? ☐ YES ☐ NO

❑ **Pre-set Oxygen**

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)**

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

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 signature Date

_____ _____ _____
Mailing Address Postal Code Phone number