River East Transcona
SCHOOL DIVISION

589 ROCH STREET, WINNIPEG, MANITOBA R2K 2P7
P 204.667.7130 F 204.661.5618 www.retsd.mb.ca

CONSENT FOR EXCHANGE OF INFORMATION

I, _____
(parent/guardian's name)

_____

give consent for the **River East Transcona School Division** to receive and/or give information about

_____ _____
(child's full name) (child's birth date)

- Information may concern this child's speech, language, intellectual, emotional and social development and educational, psychiatric, hearing or health needs.
- Information may be exchanged in written or spoken form.

This information may be received from and/or given to:

_____
(Name/Agency)

_____
(Address) (Postal Code)

This information will be used for:

_____
(purpose)

_____

_____

Information received by the division will be kept in a confidential file and be seen only by those people working on behalf of this child.

It is my choice to give consent. I understand that I may withdraw this consent at any time by notifying the division in writing.

_____ _____
Signature of parent/guardian Date

_____ _____
Witness Date

Telephone Consent: This consent form was discussed with the parent/guardian who verbally consented to exchange of information.

Name: (please print) _____

Signature: _____ Date: _____

gc Jan29.09(Forms)

Document No: ☐

SCHOOL REGISTRATION FORM: Children in Care

(Form available at www.manitoba.ca/healthychild/publications)

(Please check off Authority you represent)

☐ Métis Family Services Authority

☐

☐

☐ The General Child and Family Services Authority

DEMOGRAPHICS

Name: _____

Date of Birth: _____

MET#: _____ PHIN: _____

Legal Guardian/Agency: _____

Mailing Address: _____

Phone Number: _____ Fax Number: _____

Child and family services worker: _____

Phone Numbers

Office: _____ Mobile: _____

Fax Number: _____ Email: _____

Foster Placement: _____

Mailing Address: _____

Phone Number: _____ Email: _____

CHILD AND FAMILY SERVICES STATUS (Check which best applies, provide date(s))

☐ Voluntary Placement Agreement _____ (date)

☐ Voluntary Surrender of Guardianship _____ (date)

☐ Extension of Care _____ (date)

☐ Apprehension _____ (date)

☐ Supervision Order _____ (date)

☐ Temporary Order of Guardianship to _____ (date)

☐ Permanent Order of Guardianship _____ (date)

Expected length of placement (emergency or long-term): _____

Approved for Contact:

Name: _____ Role: _____

Name: _____ Role: _____

Name: _____ Role: _____

SCHOOL INFORMATION

Last School Attended: _____

Contact Person: _____

Phone Number: _____

Address: _____

Current Grade Attended: _____

Grade Level Functioning (Check description that best applies):

☐ Meets ☐ Exceeds ☐ Below

Relevant Educational Programming Information:

_____

_____

_____

_____

Community supports provided by the agency:

_____

_____

_____

_____

Areas of interest/strengths (e.g., hobbies, clubs, organizations, cultural interests):

_____

_____

_____

_____

Relevant Medical Information:

_____

_____

_____

_____

_____

Additional Information and relevant life situation:

_____

_____

_____

_____

CONTACT DATA AND AUTHORIZATION:

Printed Name of Placing Child
and Family Services Worker: _____

Signature of Placing Child
and Family Services Worker: _____

Date Signed: _____

Name of Placing Agency Office/Regional Office: _____

Address of Placing Agency Office/Regional Office:

_____

_____

Phone # of Placing Child and Family Services Worker: _____

Printed Name of Agency
E.D. C.E.O. /Regional Office R.D.: _____

Signature of Placing Agency
E.D. C.E.O. /Regional Office R.D.: _____

Date Signed: _____

Address of Placing Agency E.D. C.E.O. /Regional Office R.D.:

_____

_____

Phone # of Placing Agency E.D. C.E.O. /Regional Office R.D.: _____

Printed Name of Parent: _____

Signature of Parent: _____ Date Signed: _____

Printed Name of Student: _____

Signature of Student: _____ Date Signed: _____
(if 18 or over)

For School/Division Office Use:

Steps	Date	Principal or Designate Signature
Registration Received:		
Intake Meeting (as required):		
Start Date:		
Follow-up/Review Meeting(s) (as required):		

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: City/Town: POSTAL CODE:

Section II - Child information

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

Also Known As

month (print) D D Y Y Y Y

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

River East Transcona
SCHOOL DIVISION

760 KILDARE AVENUE E., WINNIPEG, MANITOBA R2C
P 204.222.9577 F 204.224.2783 www.retsd.m

Student Entry Information for John G Stewart School Intake Meeting

Student Last Name:	Student First Name:
Placement at Knowles-	Emergency Phone #:
Birthdate:	Male / Female
Former School:	Division:
Contact Name & Phone:	Grade/Program:
Social Worker Name & Phone:	MET #:
Information Received From:	

Date: O Face-to-Face O Telephone O Written O Other

In Attendance:

Form Completion	
☐ Registration	☐ Media Coverage Permission
☐ Aboriginal Identity form	☐ Review of policies
☐ Health Education	☐ Immunization Consent
☐ Out of School Activities	☐ Consent for information
☐ Computer Use	☐ Child in Care Form

Medical Needs :

☐ Uris if Applicable

Prime Needs of student:

Strengths/Interests/Motivators:

Access Concerns

- ☐ Child in Care
- ☐ Custody
- ☐ Parental Communications
- ☐ Restraining order
- ☐ Other:

Academic History

Current Grade-
Schools Attended-

Reason for Alternative Placement-

Academic Concerns (Funded/ IEP/ Modified/ AEP)-

Achievement concerns (missing credits, failures)-

Behaviour Concerns
(verbal, physical, sexual, offending behaviour) Is there a BIP/Safety Plan
Describe Minor Behaviours and Extreme Behaviours
Attendance Concerns- AWOL concerns- multiple schools/placements/interrupted schooling
Any safety concerns for self or others at previous schools or home?

Student Specific Programming
Any Diagnosis
Any present testing (Psychology or other) Date/Result:

Social/Emotional Issues

- ☐ Alcohol/Drug Use
- ☐ Anxiety
- ☐ Bullying
- ☐ Depression
- ☐ Grief/Loss issues
- ☐ Motivational Issues
- ☐ Parental separation/divorce
- ☐ Self- Harm
- ☐ Suicidal Attempts
- ☐ Suicidal Thoughts
- ☐ Traumatic History
- ☐ Victim of bullying
- ☐ Other

Outside Agency Support

- ☐ AFM mandatory Counseling
- ☐ Threat Assessment (have there been any completed, when and results)
- ☐ Expulsion or suspensions from previous school
- ☐ Police- probation involvement
- ☐ MYC Involvement
- ☐ Counseling or therapy (Name of outside agency)
- ☐ Other

Any support need that needs to be enrolled?

Any other supports required for this student to be successful in school?

Next Meeting Date-

Additional Notes Page:
Student Intake Meeting for: _____ Date: