

# Turtle River School Division

P.O. Box 309 McCreary Mb. R0J 1B0  
Telephone 204-835-2067 Fax 204-835-2426  
Email divoffice@trsd32.mb.ca

Bev Szymesko  
Superintendent of Schools

Shannon Desjardins  
Secretary Treasurer

## Consent for the Release of Information

I, \_\_\_\_\_, hereby give consent  
(Full Name)

to \_\_\_\_\_  
(Name of Party who is to release the information)

of \_\_\_\_\_  
(Address of Party who is to release the information)

to release the following information:

\_\_\_\_\_ Medical/Physical Condition  
\_\_\_\_\_ Resource Reports/Tests  
\_\_\_\_\_ Psychologist/Speech Pathologist  
\_\_\_\_\_ Other Confidential Material

of \_\_\_\_\_  
(Student's Name and Address)

to Ste Rose School  
(Name of Party to Receive Information)

of Box 129 . Ste Rose du Lac, MB R0L 1S0  
(Address of Party to Receive Information)

to Resource Dept  
(Description of how information will be used)

I understand that this information will be used for professional purposes only.

Signed \_\_\_\_\_

Date \_\_\_\_\_

*"Learning today for tomorrow"*

# TURTLE RIVER SCHOOL DIVISION STUDENT REGISTRATION FORM



**OFFICE USE**

Entry Date: \_\_\_\_\_

SCHOOL \_\_\_\_\_

MET NO. \_\_\_\_\_

STUDENT NO. \_\_\_\_\_

DATE \_\_\_\_\_

Information to be entered by Student's Parents/Guardians – PLEASE NOTIFY SCHOOL IF ANY INFORMATION CHANGES

## STUDENT INFORMATION (Please Print)

Please fill in and return to the school as soon as possible.

Legal Last Name \_\_\_\_\_ Birth Date: \_\_\_\_\_ Verified ☐

Type of Identification: \_\_\_\_\_

First Name \_\_\_\_\_ Second Name \_\_\_\_\_

Name Known by \_\_\_\_\_

Languages(s) Spoken at Home: ☐ English ☐ Oji-Cree ☐ French ☐ Other (please list \_\_\_\_\_)

Current or Last School Attended: \_\_\_\_\_ Division: \_\_\_\_\_

School's Address: \_\_\_\_\_ School's Phone No: \_\_\_\_\_

Last Grade Completed: \_\_\_\_\_ Grade Registering In: \_\_\_\_\_

Treaty Number: \_\_\_\_\_ Band Name: \_\_\_\_\_

## STUDENT MAILING ADDRESS

Apt. No. /Street: \_\_\_\_\_ Community/Town/Village/City: \_\_\_\_\_

P.O. Box No: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Student Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Section/township/range \_\_\_\_\_ Bus Driver: \_\_\_\_\_ (if known)

**STUDENT REGISTRATION FORM** 'continued'

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**PARENT/LEGAL GUARDIAN AND CONTACT INFORMATION**

Legal Custody (only if applicable) ☐ Joint ☐ Father ☐ Mother ☐ Guardian ☐ Other (please note) \_\_\_\_\_  
☐ Agency (please note) \_\_\_\_\_

**Parent or Legal Guardian** ☐ **Student lives with**

Relation to Student: \_\_\_\_\_

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Address if different from above: \_\_\_\_\_

City/Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell/Other Phone \_\_\_\_\_

Email \_\_\_\_\_

Employer: \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

**Parent or Legal Guardian** ☐ **Student also lives with**

Relation to Student: \_\_\_\_\_

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Address if different from above: \_\_\_\_\_

City/Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell/Other Phone \_\_\_\_\_

Email \_\_\_\_\_

Employer: \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

**Parent or Legal Guardian** ☐ **Student also lives with**

Relation to Student: \_\_\_\_\_

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Address if different from above: \_\_\_\_\_

City/Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell/Other Phone \_\_\_\_\_

Email \_\_\_\_\_

Employer: \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

**EMERGENCY CONTACT** (if parent/guardian cannot be reached)

Relation to Student: \_\_\_\_\_

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Address: \_\_\_\_\_

City/Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell/Other Phone \_\_\_\_\_

Email \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

**EMERGENCY BILLET** - Name of town billet (friend or relative that lives in town where child can stay in

case of a storm: \_\_\_\_\_ Phone No. \_\_\_\_\_

**FAMILY – Pre-School/School Age Siblings**

Name: \_\_\_\_\_ Gr. \_\_\_\_\_ School \_\_\_\_\_ Age \_\_\_\_\_

Name: \_\_\_\_\_ Gr. \_\_\_\_\_ School \_\_\_\_\_ Age \_\_\_\_\_

Name: \_\_\_\_\_ Gr. \_\_\_\_\_ School \_\_\_\_\_ Age \_\_\_\_\_

Name: \_\_\_\_\_ Gr. \_\_\_\_\_ School \_\_\_\_\_ Age \_\_\_\_\_

Name: \_\_\_\_\_ Gr. \_\_\_\_\_ School \_\_\_\_\_ Age \_\_\_\_\_

## STUDENT REGISTRATION FORM

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### MEDICAL INFORMATION

Manitoba Health Registration No. \_\_\_\_\_ Personal Health I.D. No. \_\_\_\_\_

Health Concerns/Allergies: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

### INDIGENOUS IDENTIFICATION DECLARATION

#### **Indigenous Identity Declaration** Authorization and Statement of Understanding

*Indigenous Identity Declaration helps to support the efforts of Manitoba Education and Training and school divisions to plan and improve programs in a way that is responsive to Indigenous learners. (Providing this personal information is voluntary and optional. It is being collected in compliance with section 36(1)(b) of The Freedom of Information and Protection of Privacy Act as it is necessary for and relates directly to the activity of Manitoba and school divisions to plan, deliver and improve programs.)*

1. I, \_\_\_\_\_, (name of parent/guardian, please print clearly):
  - ☐ Am submitting my child's Indigenous Identity Declaration for the first time
  - ☐ Am making changes to my child's Indigenous Identity Declaration
  - ☐ Already submitted my child's Indigenous Identity Declaration and have no further changes to make at this time.
  
2. Is your child an Indigenous person, that is, First Nation (North American Indian), Métis, or Inuk (Inuit)? **Note: First Nations (North American Indian) include Status and Non-Status Indians**
  - If "Yes", mark the square(s) that best describe(s) your child now:
    - ☐ Yes, First Nation (North American Indian)
    - ☐ Yes, Métis
    - ☐ Yes, Inuk (Inuit)
  
3. Which best describes your child's Indigenous cultural-linguistic identity?  
Please select up to two choices:
  - ☐ Anishinaabe (Ojibway/Saulteaux)
  - ☐ Ininiw
  - ☐ Dene (Sayisi)
  - ☐ Dakota
  - ☐ Oji-Cree
  - ☐ Michif
  - ☐ Inuktitut
  - ☐ Other-please specify: \_\_\_\_\_

**INFORMED CONSENT**

(MEDIA, STUDENT WORK, ELECTRONIC COMMUNICATION, AND COMPUTER AND INTERNET USAGE)

**ELECTRONIC COMMUNICATION – Student usage of division email and sharing of information through email (e.g. Newsletters, etc.)**

As students complete activities and assignments, they are expected to submit and communicate electronically with email. Email is an important 21<sup>st</sup> century skill that students need to learn to use effectively in order to prepare them for the world. Being efficient in using email as a form of electronic communication is expected of students in our schools. Students are required to be able to submit work and communicate using email.

The division is able to provide students with an email for educational use. Students are obliged to follow the division policy regarding the "proper usage" of division email and may be required by teachers to use as a way of submitting work and assignments.

\_\_\_\_\_ I GIVE CONSENT \_\_\_\_\_ I DO NOT GIVE CONSENT

-----  
As a parent/guardian I allow schools and the division to communicate with me electronically. The electronic distribution (email) of newsletters, school updates and announcements regarding division and school activities, events and news (including fundraising and promotions).

\_\_\_\_\_ I GIVE CONSENT \_\_\_\_\_ I DO NOT GIVE CONSENT

to receive information electronically and will provide my email below.

Email address: \_\_\_\_\_

**MEDIA – Television, Radio, Internet Media, and Divisional Video Productions**

As your child grows and learns, they will have the opportunity to participate in many amazing activities and experiences in our schools. We would like to share these positive experiences with the broader community by inviting journalists and other members of the media to visit our schools. Photographs, videotaping or interviews are allowed at schools only with the permission of the principal.

\_\_\_\_\_ I GIVE CONSENT \_\_\_\_\_ I DO NOT GIVE CONSENT

for my son/daughter (or myself as an adult student) being photographed, videotaped/recorded or interviewed by the media.

**STUDENT REGISTRATION FORM**

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**COMPUTER and INTERNET USAGE –Student Usage of School Computers for completing school work and the Usage of the Internet for Research and Educational Purposes**

Turtle River School Division recognizes the educational benefits of computer technology and internet access. Technology is promoted as a valuable instructional learning tool that enhances the ability of teachers to provide new and exciting learning opportunities for students. Students are supervised while using computers, the Internet, and any Information and Communication Technology (ICT). Students are taught the necessary skills to use technology and the internet in a proper manner.

I understand and will follow the guidelines as set in the division policy and school handbooks in regards to the Appropriate Use of Computers and Communication Devices. This includes the use of the Internet; including social media, text messaging and instant messaging and other forms of online communication and sharing platforms and resources that are provided by the Turtle River School Division networked computers. Access to computers and the Internet is for educational purposes as set out in the Turtle River School Division Policy. I further understand that should I commit any violation, my access privileges may be revoked and disciplinary action and/or appropriate legal action may be taken as deemed necessary. As the parent/guardian of the student, I have read the regulations for the Appropriate Use of Information Communication Technology (ICT) and the Use of Personal Communication Devices.

\_\_\_\_\_ I GIVE CONSENT \_\_\_\_\_ I DO NOT GIVE CONSENT

for my son/daughter (or myself as an adult student) to use school computers, have access to the internet, and use any of their own personal devices.

Print Name of Parent/Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_

Signature of Student (Grades 7-12 Only): \_\_\_\_\_

**STUDENT WORK, PHOTOGRAPHS, and SCHOOL PROMOTION – Publish and Display (School Display, School Newsletters, Newspapers, Division/School Webpages and Social Media)**

Our school would like to share information and communicate with parents/guardians by highlighting the school; students and student work or activities in a variety of publications and/or **Division organized or sponsored event(s)**. It will allow us to share with you the parent/legal guardian about some of the highlighted activities, work and projects your child is participating in at school. This will also showcase our school to the community and general public. Some examples of sharing include but are not limited to:

- Publication of their work (referenced appropriately) in school and division publications as printed or posted on division/school websites (*e.g. Writing compilations, submission for contests, modelling and sharing in schools, other educational purposes, etc.*).
- School or Division publications (newsletters, articles, webpages, community reports, etc.)
- Local newspaper submitted articles
- Sharing on division social media platforms (e.g. Twitter, Facebook)
- Displayed work in schools and the division office ( in the hallways, classrooms, and at various presentations and events)

**\* Please note: Student photographs posted to Turtle River School Division websites will not identify students by full name (only first name)**

\_\_\_\_\_ I GIVE CONSENT \_\_\_\_\_ I DO NOT GIVE CONSENT

to the Turtle River School Division to publish or show my child's, or my (as an adult student) photographs, name, grade, school and samples of my or my child's work in various publications and/or **at a Division organized or sponsored event**. I understand that photographs of students posted to the school or Turtle River School Division website will not identify students by full name.

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_

This personal information is being collected under the authority of The Public Schools Act for School related purposes. It is protected by the Protection of Privacy provisions of the Freedom of Information and Protection of Privacy Act and the Personal Health Information Act. If you have any questions about the collection, please contact your school principal.

**STUDENT REGISTRATION FORM**

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**REQUEST FOR BUS TRANSPORTATION**

The Public Schools Act requires school divisions to provide transportation to all students living within their division boundaries. There are occasions where some students wish to attend schools in another division. In order to address the transportation of these students in adjoining divisions Turtle River School Division has adopted the enclosed policy. This policy is intended to provide educational services in the most cost effective manner for the taxpayers of Manitoba.

\*\*\*\*\*

Please complete this form and return to:

Transportation Department  
Turtle River School Division  
Box 309  
McCreary, MB R0J 1B0

Name of Student(s)	Birthdate	Grade	Parents'/Guardians' Names
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Does your child have any health care needs that the bus driver needs to be aware of? (eg, allergies, asthma, heart condition, bleeding disorder, seizures, medication, etc.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Any special information or concerns the bus driver should be aware of: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Land Location of Residence: \_\_\_\_\_

Sec. / Twp. / Rge. OR Street Name & House #

Requesting Transportation to \_\_\_\_\_ School.

Requested date for transportation to begin: \_\_\_\_\_

Reason(s) for Requesting Transportation: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**OFFICE USE ONLY:**

Bus Driver: \_\_\_\_\_ Approx. Pick-up Time \_\_\_\_\_ AM

Transfer Bus Driver: \_\_\_\_\_ Approx. Drop-off Time \_\_\_\_\_ PM

## 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**

<b>Type of community program (please ✓)</b> <input checked="" type="checkbox"/> School <input type="checkbox"/> Licensed child care <input type="checkbox"/> Respite <input type="checkbox"/> Recreation program <input type="checkbox"/> Other: _____	<b>Community Program Name:</b> Ste. Rose School	<b>Location of Service:</b> <input checked="" type="checkbox"/> Same as on left
	<b>Contact person:</b> Shan Shankaruk	<b>Contact person:</b>
	<b>Phone:</b> 204-447-2088 <b>Fax:</b> 204-447-2457	<b>Phone:</b> <b>Fax:</b>
	<b>Email:</b> sshankaruk@trsd.ca	<b>Email:</b>
	<b>Mailing address:</b> Box 129 <b>Street address:</b> 280 Gendreau St. <b>City/Town:</b> Ste Rose d'Ar, MB <b>Postal Code:</b> R0L1S0	<b>Mailing address:</b> <b>Street address:</b> <b>City/Town:</b> <b>Postal Code:</b>

**Section II - Child information - to be completed by parent**

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

Does your child ride the bus? ☐ YES ☐ NODoes 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	<b>Life-threatening allergy and child is prescribed an injector (e.g. Epi-Pen®/ Taro Epinephrine®/ Allerject®)</b> <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	<b>Asthma (administration of medication by inhalation)</b> <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 <b>when</b> 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) <b>on their own</b> ? IF NO, describe what your child needs help with: _____
<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Seizure disorder What type of seizure(s) does the child have?</b> _____ <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	<b>Diabetes What type of diabetes does the child have?</b> <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?

Unified Referral and Intake System (URIS) Group B Application

<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Ostomy Care</b>
<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	<b>Gastrostomy Care</b>
<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	<b>Clean Intermittent Catheterization (CIC)</b>
<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	<b>Pre-set Oxygen</b>
<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	<b>Suctioning (oral and/or nasal)</b>
<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	<b>Cardiac Condition where the child requires a specialized emergency response at the community program.</b>
	What type of cardiac condition has the child been diagnosed with? _____
<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Bleeding Disorder (e.g., von Willebrand disease, hemophilia)</b>
	What type of bleeding disorder has the child been diagnosed with? _____
<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Endocrine Conditions (e.g. steroid dependence, congenital adrenal hyperplasia, hypopituitarism, Addison's disease)</b>
	What type of steroid dependence has the child been diagnosed with? _____
<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Osteogenesis Imperfecta (brittle bone disease)</b> 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 \_\_\_\_\_


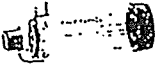
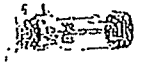

DATE (MMM/DD/YYYY) \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/Town: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Work/Daytime Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Email: \_\_\_\_\_

## INDIVIDUAL HEALTH CARE PLAN (IHCP) ASTHMA (2)

Name:		Birthdate:		Photo			
School/Community Program: <i>St. Rose School</i>							
Grade: MHSC:		PHIN:					
MedicAlert™ bracelet worn? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does the child ride the bus? <input type="checkbox"/> Yes Bus No. _____ <input type="checkbox"/> No					
Parent/Guardian Name:		Home Phone No.:		Daytime Phone No.:		Cell Phone No.:	
Parent/Guardian Name:		Home Phone No.:		Daytime Phone No.:		Cell Phone No.:	
Alternate emergency contact:		Home Phone No.:		Phone No.:		Cell Phone No.:	
Allergist:				Phone No.:			
Pediatrician/Family Doctor:				Phone No.:			
TRIGGERS: List items that most commonly trigger your child's asthma.							
RELIEVER MEDICATION (or bronchodilator) provides fast temporary relief from asthma symptoms. It is recommended that reliever medication is carried with the child so it is available if asthma episode occurs.							
What reliever medication has been prescribed for your child? (CHECK ONE)				<input type="checkbox"/> Salbutamol (e.g. Ventolin®, Novo-Salmol®) <input type="checkbox"/> Budesonide (e.g. Symbicort®) <input type="checkbox"/> Other: _____			
How many puffs of reliever medication are prescribed for an asthma episode? (CHECK ONE)				<input type="checkbox"/> 1 puff <input type="checkbox"/> 1 or 2 puffs <input type="checkbox"/> 2 puffs <input type="checkbox"/> Other: _____			
Where does your child carry his/her reliever medication?				<input type="checkbox"/> fanny pack <input type="checkbox"/> purse <input type="checkbox"/> backpack <input type="checkbox"/> other _____			
Does your child need help when using reliever medication?				<input type="checkbox"/> Yes What kind of help? _____ <input type="checkbox"/> No			
CIRCLE the type of medication device your child uses for <u>reliever medication</u> :							
 Metered dose inhaler (MDI)	 MDI with Aerochamber®	 MDI with Aerochamber® mask	 Turbuhaler®	_____ other			

*The Individual Health Care Plan and emergency medication should accompany the child on excursions outside the facility.*

Name: _____
Birthdate: _____
PHIN: _____

## STANDARD HEALTH CARE PLAN (SHCP) ASTHMA

<b>IF YOU SEE THIS:</b>	<b>DO THIS:</b>
<p><u>Signs of an asthma episode:</u></p> <ul style="list-style-type: none"> <li>▪ Coughing</li> <li>▪ Wheezing</li> <li>▪ Chest tightness</li> <li>▪ Shortness of breath</li> <li>▪ Increase in rate of breathing</li> </ul>	<ol style="list-style-type: none"> <li>1. Remove the child from triggers of asthma (e.g. exercise, cold air, smoke).</li> <li>2. Have child sit down.</li> <li>3. Ensure the child takes reliever medication (blue cap).</li> <li>4. Encourage slow deep breathing.</li> <li>5. Monitor child for improvement.</li> </ol>
<p><u>Emergency Situations:</u></p> <ul style="list-style-type: none"> <li>▪ Reliever medication has been given and there is no improvement of asthma symptoms in 5 minutes</li> <li>▪ Greyish/bluish color in lips and nail beds</li> <li>▪ Inability to speak in full sentences</li> <li>▪ Heaving of chest or chest sucking inward</li> <li>▪ Shoulders held high, tight neck muscles</li> <li>▪ Cannot stop coughing</li> <li>▪ Difficulty walking</li> </ul> <p>If asthma symptoms are severe, the child may NOT be wheezing as there is not enough air moving in the lungs to generate a wheeze.</p>	<ol style="list-style-type: none"> <li>1. Activate 911/EMS.</li> <li>2. Give reliever medication every 5 minutes.</li> <li>3. Notify parent/guardian.</li> <li>4. Stay with child until EMS personnel arrives</li> </ol>
<p><u>Signs that asthma is not controlled</u></p> <p>If staff become aware of any of the following situations, they should inform the child's parent/guardian.</p> <ul style="list-style-type: none"> <li>▪ Asthma symptoms prevent child from performing normal activities.</li> <li>▪ Child appears to be experiencing more frequent coughing, shortness of breath or wheezing.</li> <li>▪ Child is using reliever medication more than 3 times per week to relieve asthma symptoms. An exception to this includes the use of reliever medication before exercise to prevent exercise induced asthma symptoms, which then may be used up to once a day.</li> </ul>	

*I have reviewed the above plan for my child and provide consent to this plan on behalf of my child.*

Parent/guardian signature: \_\_\_\_\_ Date: yyyy/mm/dd

*I have reviewed the above plan to ensure it provides the community program with required information.*

Nurse signature: \_\_\_\_\_ Date: yyyy/mm/dd

*I have received the above plan and have notified appropriate staff.*

Program Designate signature: \_\_\_\_\_ Date: yyyy/mm/dd

☐ Instruction sheet for medication device attached

**FOR OFFICE USE ONLY:**


ANAPHYLAXIS  
INDIVIDUALIZED HEALTH CARE PLAN

Child name:		Birth date:	
Community program name: <i>St Rose School</i>		MedicAlert™ identification worn?	
Grade:		<input type="checkbox"/> YES <input type="checkbox"/> NO	
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 allergen(s):			
Other allergies (non life-threatening):			
Adrenaline auto-injector prescribed for child	Type of device	Dosage	Location
	<input type="checkbox"/> EpiPen® <input type="checkbox"/> Allerject™	<input type="checkbox"/> 0.3 mg <input type="checkbox"/> 0.15 mg	<input type="checkbox"/> Fanny pack or belt <input type="checkbox"/> Backpack <input type="checkbox"/> Purse <input type="checkbox"/> Other: _____
It is recommended that the adrenaline auto-injector be with the child during attendance at the community program. Antihistamines are NOT used in the management of life-threatening allergies in community program settings.			
Child has a back-up adrenaline auto-injector at the community program.		<input type="checkbox"/> YES Location: _____ <input type="checkbox"/> NO	
OTHER INFORMATION ABOUT MY CHILD'S LIFE THREATENING ALLERGY THAT THE COMMUNITY PROGRAM SHOULD KNOW:			

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

## ANAPHYLAXIS EMERGENCY RESPONSE PLAN

Name: _____	Birth date: _____		
<b>IF YOU SEE THIS</b>	<b>DO THIS</b>		
<p><b><u>If ANY combination of the following signs is present and there is reason to suspect anaphylaxis:</u></b></p> <p><i>When remembering the signs of anaphylaxis, think F.A.S.T (Face, Airway, Stomach, Total Body)</i></p> <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><b><u>Face</u></b></p> <ul style="list-style-type: none"> <li>red watering eyes</li> <li>runny nose</li> <li>itchiness</li> <li>redness, swelling of face, lips &amp; tongue</li> </ul> <p><b><u>Airway</u></b></p> <ul style="list-style-type: none"> <li>throat tightness</li> <li>change of voice</li> <li>difficulty swallowing</li> <li>difficulty breathing</li> <li>coughing</li> <li>wheezing</li> </ul> </td> <td style="width: 50%; vertical-align: top;"> <p><b><u>Stomach</u></b></p> <ul style="list-style-type: none"> <li>vomiting</li> <li>diarrhea</li> <li>cramps</li> </ul> <p><b><u>Total body</u></b></p> <ul style="list-style-type: none"> <li>swelling</li> <li>hives</li> <li>itchiness</li> <li>sense of doom</li> <li>change in behavior</li> <li>pale or bluish skin</li> <li>dizziness</li> <li>fainting</li> <li>loss of consciousness</li> </ul> </td> </tr> </table>	<p><b><u>Face</u></b></p> <ul style="list-style-type: none"> <li>red watering eyes</li> <li>runny nose</li> <li>itchiness</li> <li>redness, swelling of face, lips &amp; tongue</li> </ul> <p><b><u>Airway</u></b></p> <ul style="list-style-type: none"> <li>throat tightness</li> <li>change of voice</li> <li>difficulty swallowing</li> <li>difficulty breathing</li> <li>coughing</li> <li>wheezing</li> </ul>	<p><b><u>Stomach</u></b></p> <ul style="list-style-type: none"> <li>vomiting</li> <li>diarrhea</li> <li>cramps</li> </ul> <p><b><u>Total body</u></b></p> <ul style="list-style-type: none"> <li>swelling</li> <li>hives</li> <li>itchiness</li> <li>sense of doom</li> <li>change in behavior</li> <li>pale or bluish skin</li> <li>dizziness</li> <li>fainting</li> <li>loss of consciousness</li> </ul>	<ol style="list-style-type: none"> <li>1. Give adrenaline auto-injector (EpiPen or Allerject).               <ol style="list-style-type: none"> <li>i. Secure child's leg.</li> <li>ii. Identify site on outer middle thigh.</li> <li>iii. Grasp adrenaline auto-injector in fist and remove safety cap(s).</li> <li>iv. Firmly press tip into the thigh at a 90° angle until you hear a click.</li> <li>v. Hold in place for a slow count of 5.</li> </ol> </li> <li>2. Activate 911/EMS.</li> <li>3. Notify parent/guardian.</li> <li>4. If signs of anaphylaxis persist or recur, give backup adrenaline auto-injector (if available) every 5 to 15 minutes.</li> <li>5. Stay with child until EMS personnel arrive.</li> <li>6. Discard adrenaline auto-injector safely or give to EMS personnel.</li> </ol>
<p><b><u>Face</u></b></p> <ul style="list-style-type: none"> <li>red watering eyes</li> <li>runny nose</li> <li>itchiness</li> <li>redness, swelling of face, lips &amp; tongue</li> </ul> <p><b><u>Airway</u></b></p> <ul style="list-style-type: none"> <li>throat tightness</li> <li>change of voice</li> <li>difficulty swallowing</li> <li>difficulty breathing</li> <li>coughing</li> <li>wheezing</li> </ul>	<p><b><u>Stomach</u></b></p> <ul style="list-style-type: none"> <li>vomiting</li> <li>diarrhea</li> <li>cramps</li> </ul> <p><b><u>Total body</u></b></p> <ul style="list-style-type: none"> <li>swelling</li> <li>hives</li> <li>itchiness</li> <li>sense of doom</li> <li>change in behavior</li> <li>pale or bluish skin</li> <li>dizziness</li> <li>fainting</li> <li>loss of consciousness</li> </ul>		

**Risk reduction strategies** are the only way to prevent anaphylaxis. 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). Please 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 the above plan for my child and provide consent to this plan on behalf of my child.*

Parent/guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

*I have reviewed the above plan to ensure it provides the community program with required information.*

Nurse signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Documentation (Office use ONLY)**




## Ste. Rose School

280 Gendreau St. Ste. Rose du Lac, Manitoba R0L 1S0 Phone: 204-447-2088 Fax: 204-447-2457

### Consent Form - In-Town Trip/Tour

I consent to my son/daughter/custodial child's participation in teacher planned and supervised school related programs within town limits, which could take place off the school site and which begin and end on the same day. I understand that I will be informed in advance of all such programs.

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Grade

\_\_\_\_\_  
Date of Birth

-----  
**PART B: To be completed by the parent/guardian:**

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Medical # (6 digit) \_\_\_\_\_

Medical PHIN # (9 digit) \_\_\_\_\_

Medical Alert: refers to any special health condition (i.e. diabetes, asthma, allergies, etc.) and level of severity. Please indicate what special treatment is required if attacks should occur:

\_\_\_\_\_  
\_\_\_\_\_

Person to contact in case of an emergency: \_\_\_\_\_

Telephone number (home) \_\_\_\_\_ (work) \_\_\_\_\_ other \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ (home) \_\_\_\_\_ (work) \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian