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 _____

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)*

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 _____

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 21st 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.

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.

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

PRAIRIE MOUNTAIN HEALTH

Community Program Representative ☐

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 √)*	Community Program Name: Ste. Rose School	Location of Service: ☑ Same as on left
☑ School ☐ Licensed child care ☐ Respite ☐ Recreation program ☐ Other: _____	Contact person: Shari Shankaruk	Contact person:
	Phone: 204-447-2088 Fax: 204-447-2457	Phone: Fax:
	Email: sshankaruk@frsd.ca	Email:
	Mailing address: Box 129 Street address: 280 Gendreau St. City/Town: Ste Rose du Lac, MB Postal Code: R0L1S0	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** ☐ 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 (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.

☐ 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 (MMM/DD/YYYY)*

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

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

Email: _____

PRAIRIE MOUNTAIN HEALTH

INDIVIDUAL HEALTH CARE PLAN (IHCP)
ASTHMA (2)

Name:		Birthdate:	Photo
School/Community Program: Ste. Rose School			
Grade:	MHSC:	PHIN:	
MedicAlert™ bracelet worn? ☐ Yes ☐ No	Does the child ride the bus? ☐ Yes Bus No. _____ ☐ 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.:	

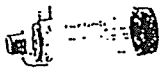
TRIGGERS: List items that most commonly trigger your child's asthma.

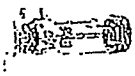
RELIEVER MEDICATION (or bronchodilator) provides fast temporary relief from asthma symptoms. It is recommended that reliever medication is carried with the child so it is available if asthma episode occurs.

What reliever medication has been prescribed for your child? (CHECK ONE)	☐ Salbutamol (e.g. Ventolin®, Novo-Salmol®) ☐ Budesonide (e.g. Symbicort®) ☐ Other: _____
How many puffs of reliever medication are prescribed for an asthma episode? (CHECK ONE)	☐ 1 puff ☐ 1 or 2 puffs ☐ 2 puffs ☐ Other: _____
Where does your child carry his/her reliever medication?	☐ fanny pack ☐ purse ☐ backpack ☐ other _____
Does your child need help when using reliever medication?	☐ Yes What kind of help? _____ ☐ 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

IF YOU SEE THIS: ➔	DO THIS:
Signs of an asthma episode: * Coughing * Wheezing * Chest tightness * Shortness of breath * Increase in rate of breathing	1. Remove the child from triggers of asthma (e.g. exercise, cold air, smoke). 2. Have child sit down. 3. Ensure the child takes reliever medication (blue cap). 4. Encourage slow deep breathing. 5. Monitor child for improvement.
Emergency Situations: * Reliever medication has been given and there is no improvement of asthma symptoms in 5 minutes * Greyish/bluish color in lips and nail beds * Inability to speak in full sentences * Heaving of chest or chest sucking inward * Shoulders held high, tight neck muscles * Cannot stop coughing * Difficulty walking 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.	1. Activate 911/EMS. 2. Give reliever medication every 5 minutes. 3. Notify parent/guardian. 4. Stay with child until EMS personnel arrives
Signs that asthma is not controlled **If staff become aware of any of the following situations, they should inform the child's parent/guardian.** * Asthma symptoms prevent child from performing normal activities. * Child appears to be experiencing more frequent coughing, shortness of breath or wheezing. * 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.	

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:

PRAIRIE MOUNTAIN HEALTH
SANTÉ PRAIRIE MOUNTAIN

ANAPHYLAXIS
INDIVIDUALIZED HEALTH CARE PLAN

Child name:	Birth date:
Community program name: St Rose School	MedicAlert™ identification worn? ☐ YES ☐ NO
Grade:	
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
	☐ EpiPen® ☐ Allerject™	☐ 0.3 mg ☐ 0.15 mg	☐ Fanny pack or belt ☐ Backpack ☐ Purse ☐ 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. ☐ YES ☐ NO Location: _____

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.

PRAIRIE MOUNTAIN HEALTH
SANTÉ PRAIRIE MOUNTAIN

ANAPHYLAXIS
EMERGENCY RESPONSE 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:

When remembering the signs of anaphylaxis, think F.A.S.T (Face, Airway, Stomach, Total Body)

Face
- red watering eyes
- runny nose
- itchiness
- redness, swelling of face, lips & tongue

Airway
- throat tightness
- change of voice
- difficulty swallowing
- difficulty breathing
- coughing
- wheezing

Stomach
- vomiting
- diarrhea
- cramps

Total body
- swelling
- hives
- itchiness
- sense of doom
- change in behavior
- pale or bluish skin
- dizziness
- fainting
- loss of consciousness

1. Give adrenaline auto-injector (EpiPen or Allerject).
   i. Secure child's leg.
   ii. Identify site on outer middle thigh.
   iii. Grasp adrenaline auto-injector in fist and remove safety cap(s).
   iv. Firmly press tip into the thigh at a 90° angle until you hear a click.
   v. Hold in place for a slow count of 5.
2. Activate 911/EMS.
3. Notify parent/guardian.
4. If signs of anaphylaxis persist or recur, give backup adrenaline auto-injector (if available) every 5 to 15 minutes.
5. Stay with child until EMS personnel arrive.
6. Discard adrenaline auto-injector safely or give to EMS personnel.

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

STE. ROSE SCHOOL
LOCK & LOCKER FORM

NAME _____ **Grade:**_____

ADDRESS _____

_____

PHONE NO. _____

LOCKER NO. _____

LOCK NO. _____

COMBINATION _____

My signature on this form acknowledges the receipt and responsibility of a lock and locker. In addition, I understand the locker and lock are the property of Ste. Rose School and subject to inspections with or without student permission at the discretion of the principal.

The school requires that only a school-supplied lock be used on the locker. Students are asked not to leave valuables or money in their locker. Students may use the school safe to store such valuables.

My signature indicates I have read and understood the conditions stated above.

STUDENT SIGNATURE _____

PARENT SIGNATURE _____

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**