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**

month (print) D D Y Y Y Y

Also Known As

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?

Manitoba
Family Services
and Housing

Manitoba
Education, Citizenship
and Youth

Manitoba
Health

☐ **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

Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

STANDARD HEALTH CARE PLAN (SHCP)
ANAPHYLAXIS

Name:	**Gender:**	**Birth date:**
Community program name:		**Grade (if applicable):**
MedicAlert™ identification worn ? ☐ YES ☐ NO		**MHSC #:**
		PHIN #:
Parent/guardian name:		
Home Ph#:	**Cell #:**	**Work #:**
Parent/guardian name:		
Home Ph#:	**Cell #:**	**Work #:**
Alternate emergency contact name:		
Home Ph#:	**Cell #:**	**Work #:**
Allergist:		**Phone #:**
Pediatrician/Family doctor:		**Phone #:**

List items(s) that your child has a life-threatening allergy to (e.g., peanuts, nuts, milk, eggs):

Other allergies (non life-threatening):

Adrenaline auto-injector

It is recommended that the adrenaline auto-injector is **with** the child at all times while attending the community program (e.g., school, child care facility).

Type
- ☐ EpiPen®
- ☐ Twinject®
- ☐ Allerject™

Dosage
- ☐ 0.3 mg
- ☐ 0.15 mg

Location at community program
- ☐ Fanny pack or belt
- ☐ Backpack
- ☐ Purse
- ☐ Other _____

Back-up adrenaline auto-injector is available at the community program.
- ☐ NO
- ☐ YES – Describe location _____

Antihistamines are NOT used in the management of life-threatening allergies in community program settings.

This health care plan should accompany the child on excursions outside the facility.

Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

STANDARD HEALTH CARE PLAN (SHCP)
ANAPHYLAXIS

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.
   i. Secure child's leg.
   ii. Identify site on outer middle thigh.
   iii. Grasp adrenaline auto-injector in fist and remove safety cap(s). Do not bend or twist it off.
   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.

The Twinject® has a 2nd dose which community program personnel do NOT use as it is not a safety regulated needle.

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 can also 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 and information provided to me, and in my opinion, this is an appropriate response plan for this child.

Nurse name & signature: _____ **Date:** _____

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ASTHMA STANDARD HEALTH CARE PLAN (SHCP)

Name:	**Gender:**	**Birth date:**
Community program:		**Grade:**
MedicAlert™ identification worn? ☐ YES ☐ NO		**MHSC:**
		PHIN:
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:		

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®, Novo-Salmol®) ☐ 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 need help when using reliever medication?	☐ Yes What kind of help? _____ ☐ No	

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

Metered dose inhaler (MDI)

MDI with AeroChamber®

MDI with AeroChamber® mask

Turbuhaler®

_____ other

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

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ASTHMA STANDARD HEALTH CARE PLAN (SHCP)

Name:	Birth date:

IF YOU SEE THIS:	DO THIS:
Signs 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 (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 of asthma symptoms.
Emergency situations • Reliever medication has been given and there is no improvement of asthma symptoms in five 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	1. Activate 911/EMS. 2. Give reliever medication every five 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 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 symptoms or with exercise.

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

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

I have reviewed the above plan and agree that it is appropriate for this child:

Nurse name & signature: _____ **Date:** _____

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☐ **Instruction sheet for medication device attached**