



Authorization for Release of Personal Health Information

Name of Child: _____

Date of Birth: _____ Phone: _____

Parent(s) Name: _____

Address: _____ Postal Code: _____

School Division: Beautiful Plains School Division

School: _____

I, _____ hereby authorize Beautiful Plains School Division
(Parent/Guardian)

to release/receive information regarding my child _____

from Assiniboine Regional Health Authority, for the purpose of developing an Individual Health Care and/or a Medical Response Plan.

I understand this information is confidential and will be used by the recipient only for the purpose of providing a service to the student.

This consent remains in effect as long as the health plan is required.

Signed: _____ Date: _____

Witness: _____ Date: _____

Identification of Students Requiring Health Procedures

Child's Name: _____

_____ No medical/health concerns or conditions.

HEALTH CARE NEEDS

| | |
|---|--|
| Please check all health care needs that the your child requires during attendance at school. | |
| <input type="checkbox"/> | Life-threatening allergy (and child is prescribed an Epi-pen) Does your child bring an Epi-pen to school? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | Asthma (administration of medication by inhalation) Does your child bring asthma medication (puffer) to school? <input type="checkbox"/> Yes <input type="checkbox"/> No Can the child take the asthma medication (puffer) on his/her own? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | Seizure disorder (when specific skills are needed) What type of seizure(s) does your child have? _____ Does your child require administration of rescue medication (e.g. lorazepan)? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | Diabetes (responding to low blood sugar emergencies) What type of Diabetes does your child have? <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 Does your child require assistance with blood sugar monitoring? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | Cardiac condition where your child requires specialized emergency response at school. What type of cardiac condition does your child have? _____ |
| <input type="checkbox"/> | Bleeding disorder (e.g Von Willebrands, Hemophilia) What type of bleeding disorder does your child have? _____ |
| <input type="checkbox"/> | Steroid dependency (Adrenal hyperplasia, hypopituitarism, adrenal insufficiency, Addison's Disease) What type of steroid dependence does the child have? _____ |
| <input type="checkbox"/> | Gastrostomy Care Does your child require gastrostomy tube feeding at school? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your child require administration of medication via the gastrostomy tube at school? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | Ostomy Care Does your child need an ostomy bag to be emptied at school? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your child need an ostomy appliance to be changed at school? <input type="checkbox"/> Yes <input type="checkbox"/> No Does your child require assistance with these routines? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> | Clean Intermittant Catherization |
| <input type="checkbox"/> | Pre-set Oxygen |
| <input type="checkbox"/> | Suctioning (oral or nasal) |

Child's Bus Driver (if applicable): _____

If medical/health condition is indicated, "**Authorization for Release of Personal Health Information**" form required (See reverse side)