



<input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> <b>Cardiac Condition</b> (where the child requires a specialized emergency response at the community program). What type of cardiac condition has the child been diagnosed with? _____
<input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> <b>Bleeding Disorder</b> (e.g., von Willebrand disease, hemophilia) What type of bleeding disorder has the child been diagnosed with? _____
<input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> <b>Steroid Dependence</b> (e.g., congenital adrenal hyperplasia, hypopituitarism, Addison's disease) What type of steroid dependence has the child been diagnosed with? _____
<input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> <b>Osteogenesis Imperfecta (brittle bone disease)</b> What type? _____
<input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> <b>Gastrostomy Feeding Care</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> Does the child require gastrostomy tube feeding at the community program? <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> Does the child require administration of medication via the gastrostomy tube at the community program?
<input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> <b>Ostomy Care</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> Does the child require the ostomy pouch to be emptied at the community program? <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> Does the child require the established appliance to be changed at the community program? <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> Does the child require assistance with ostomy care at the community program?
<input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> <b>Clean Intermittent Catheterization (IMC)</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> Does the child require IMC? <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> Does the child require assistance with IMC at the community program?
<input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> <b>Pre-set Oxygen</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> Does the child require pre-set oxygen at the community program? <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> Does the child bring oxygen equipment to the community program?
<input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> <b>Suctioning (oral and/or nasal)</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> Does the child require oral and/or nasal suctioning at the community program? <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> Does the child bring suctioning equipment to the community program?

### 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 Name (Please Print)

\_\_\_\_\_  
 Parent/ Legal Guardian Signature

\_\_\_\_\_  
 Date

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

\_\_\_\_\_  
 Postal Code

\_\_\_\_\_  
 Home Telephone Number

\_\_\_\_\_  
 Work & Cell Number

\_\_\_\_\_  
 E-Mail Address