ADMINISTRATION OF HEALTH CARE PROCEDURES

Policy G.1.M

Frontier School Division is committed to providing educational services for all students. The Division acknowledges that some students may require medical procedures to be performed during the time the child is in school. Students who require such procedures may have a disability and/or life long medical condition requiring special health care. The Division will administer the procedures provided all requirements in the regulations are met.

Information: Manitoba Family Services, Unified Referral and Intake System (URIS)

Adopted September 1, 2009		

ADMINISTRATION OF HEALTH CARE PROCEDURES

Regulation G.1.M-R

The Division will administer health care procedures according to the following regulations.

1. Responsibilities of Parents/Guardians

Parents/Guardians shall:

a. complete the written authorization for procedures to be carried out during the school day, as indicated on "Authorization for Health Care Procedures" (Parents/Guardians) form (EXHIBIT G.1.M- EX1),

b. complete the "Unified Referral and Intake System "(URIS) application (EXHIBIT G.1.M-EX2),

c. complete the application "Authorization for the Release of Medical Information" form (EXHIBIT G.1.M-EX 3),

d. provide written instructions for carrying out health care procedures including the completion of the "Authorization for Health Care Procedures" (Doctor and /or Health Care Practitioner) form (EXHIBIT G.1.M-EX 4),

e. participate in the development of a Health Care Plan (EXHIBIT G.1.M-EX5),

f. notify the school immediately of any required changes in procedures and provide updated written instructions for carrying out health care procedures from a qualified health care professional,

g. provide any necessary materials/supplies required to carry out the responsibilities as indicated in the Health Care Plan (EXHIBIT G.1.M-EX5).

2. Responsibility of the Principal

The Principal shall:

a. obtain written "Authorization for Health Care Procedures" (Parent/Guardians) form (Exhibit G.1.M-EX1),

b. confirm completion and submission of the Unified Referral and Intake System Application (Exhibit G.1.M-EX2) where applicable,

c. obtain completed "Authorization for the Release of Medical Information" (Exhibit G.1.M-EX3),

d. obtain written instructions for carrying out health care procedures from the family physician or health care professional, including the completed "Authorization for Health Care Procedures" (Doctor and/or Health Care Practitioner) form (Exhibit G.1.M-EX4),

e. ensure that the necessary procedures have been outlined in a completed Health Care Plan (Exhibit G.1.M-EX5) with participation of the student's in-school team, the parent/guardian, and the health care professional,

f. confirm with the appropriate medical professional whether employees can be properly trained to perform the required procedure, identify appropriate employees for training, and ensure training is provided,

g. ensure on-going supervision of procedures and re-training as required by a qualified health care professional,

h. maintain a record of the training of each employee who is required to perform the procedures, with appropriate date, name of employee and signature of trainer,

i. maintain a record of completed health care procedures as per the Health Care Plan, and ensure each entry is dated and signed,

j. designate a specific area, with limited access for storage of necessary equipment/materials,

k. notify the parent/guardian and/or health care professional in a timely manner of observed changes or concerns,

l. ensure the above process is completed annually, and whenever staffing and/or required procedures change,

m. notify the parent/guardian when concerns arise regarding the necessary materials/supplies.

Adopted September 1, 2009		

AUTHORIZATION FOR HEALTH CARE PROCEDURES
To be completed by Parents/Guardians

Student's Name:_____ Birth date:_____

Address:_____

School:_____ Date:_____

I hereby request and authorize that my child receive at school, the health care procedures as described by our doctor and/or health care practitioner. The administration of such health care procedures are to be the responsibility of the principal or his or her designate.

This authorization is considered valid until _____ (no later than June 30 next following this date) unless withdrawn by the doctor, health care practitioner or parent.

We understand and agree that the Division agrees to perform the necessary procedure in exchange for this release from liability. We understand that the medical procedure will not be performed by a medical professional.

Further, we agree that we will keep the Division apprised of any changes in medical procedure(s) to be performed.

_____ _____
Signature of Witness Signature of Parent/Guardian

_____ _____
Date Date

Adopted September 1, 2009		

Unified Referral and Intake System (URIS) Group A 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 A.

Section I – Community program information (to be completed by the community program)

Type of community program (please √)	Name of community program:
❑ School ❑ Licensed child care ❑ Respite ❑ Recreation 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.

❑ **Ventilator Care**	❑ **Registered nurse to perform health care procedure(s) required by child.**
❑ **Tracheostomy Care**	❑ **Orientation/training for the registered nurse.**
❑ **Suctioning (Tracheal/Pharyngeal)**	❑ **Coverage by an alternate registered nurse to allow the primary nurse to attend interdisciplinary planning meetings related to the child.**
❑ **Nasogastric tube care and/or feeding**	❑ **Some specialized medical equipment and required maintenance.**
❑ **Complex administration of medication [i.e., via infusion pump, nasogastric tube or injection (other than Auto-injector)]**	❑ **Limited consumable health care items.**
❑ **Central or peripheral venous line intervention**	❑ **Some transportation costs related to medical needs of child.**
❑ **Other clinical interventions requiring judgments and decision making by a medical or nursing professional**	❑ **Auditory intercom system/pager/cell phone.**
	❑ **Other**

Please check (√) the support required by the child at the community program. Refer to the URIS Policy and Procedure Manual for additional information.

Please attach a completed URIS Group B application if necessary.

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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

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 √)	Name of community program:
❑ School ❑ Licensed child care ❑ Respite ❑ Recreation 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? _____

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☐ **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

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Exhibit G.1.M-EX3

I, _____ of _____ authorize
(Parent/Guardian) (Address)

Frontier School Division to exchange and release medical information and consult with physician if required for the purpose of developing an Individual Health Care Plan and/or Emergency Plan for

_____
(Student's Name)

I understand as the parent/guardian that I may amend or revoke this decision at any time with written correspondence.

_____
(Parent/Guardian Signature)

_____
(Witness Signature)

_____
(Date)

This contract expires June 30, or when the child leaves Frontier School Division or if there is a change in either custody or legal guardianship, in which case, a new form must be completed.

Note: A copy of this form is to be sent to the Area Special Services Consultant and the original is to be kept in the student's file.

Adopted September 1, 2009		

AUTHORIZATION FOR HEALTH CARE PROCEDURES

Exhibit G.1.M-EX4

(DOCTOR AND/OR HEALTH CARE PRACTITIONER)

I hereby agree and give permission for this child, _____, to receive the following health care procedures at school. Such procedures are to be carried out in accordance with Division policy and regulations. I further agree to keep the Division apprised of any changes in the medication to be administered and/or the procedure to be performed.

Health Care Procedures:

_____

_____

_____

Frequency and method of performing the health care procedures:

_____

_____

_____

Risk considerations if any:

_____

_____

_____

Level of training required before the school employee can carry out the health care procedures:

_____

_____

_____

_____ _____

Date Signature of Physician and/or Health Care Practitioner

_____ _____

Telephone Address

Adopted September 1, 2009		

INDIVIDUAL HEALTH CARE PLAN

Exhibit G.1.M-EX5

Date Completed _____

School _____ Phone _____

Teacher _____ Grade _____

Release of Information/Consent Signed (copy attached – Exhibit G.1.M-EX3)

STUDENT INFORMATION

Name _____ Date of birth _____

Address _____

M.E.T.# _____ Treaty# _____

MB Health# _____ MHSC PHIN# _____

Parents/Guardians: _____ Phone _____

Primary Caregiver (if other than guardian): _____ Phone _____

Emergency Contact Person _____ Phone _____

HEALTH CARE INFORMATION

Family Physician _____

Address _____ Phone _____

Consulting Physician _____

Address _____ Phone _____

Area of Expertise _____

Other Health Care Professionals _____

Diagnosis _____

INDIVIDUAL HEALTH CARE PLAN

Exhibit G.1.M-EX5

Presenting Health Care Needs_____

_____

_____

Plan Participants

Name	Role
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Review Date_____

HEALTH CARE PLAN

The Health/Nursing Care Plan was developed or recommended by:

_____ Date_____
(Health Care Professional)

Health Care Plan (check where appropriate)

_____is attached and/or _____is described below

PROCEDURES
(what, where, when, how, supplies/equipment)

_____

_____

_____

_____

INDIVIDUAL HEALTH CARE PLAN

Exhibit G.1.M-EX5

PRECAUTIONS

_____

_____

_____

_____

EMERGENCY PROCEDURES

Contact Person_____ Phone_____

Alternate_____ Phone_____

If you see this:	Do this:
_____	_____
_____	_____
_____	_____
_____	_____

TRANSPORTATION PLAN_____

_____

_____

Name of Adult Accompanying Child_____

RECORD OF PERSONNEL TRAINING

Primary Person trained_____

Date trained_____

Date recommended for retraining_____

Back-up person(s) trained_____

_____

INDIVIDUAL HEALTH CARE PLAN

Exhibit G.1.M-EX5

Training Provided by_____

Level and description of training_____

_____

Name of Trainer (please print)	Signature	Date
Name of Principal (please print)	Signature	Date

Adopted September 1, 2009		