



<input type="checkbox"/> Gastrostomy Feeding Care	
Does the child require gastrostomy tube feeding at the community program?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the child require administration of medication via the gastrostomy tube at the community program?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Ostomy Care	
Does the child require the ostomy pouch to be emptied at the community program?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the child require the established appliance to be changed at the community program?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the child require assistance with ostomy care at the community program?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Clean Intermittent Catheterization (CIC)	
Does the child require assistance with CIC at the community program?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Pre-set Oxygen	
Does the child require pre-set oxygen at the community program?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the child bring oxygen equipment to the community program?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Suctioning (Oral and/or Nasal)	
Does the child require oral and/or nasal suctioning at the community program?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the child bring suctioning equipment to the community program?	<input type="checkbox"/> YES <input type="checkbox"/> 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 (**Please Print**) _____

Parent/Legal Guardian (**Signature**) _____ Date _____

Mailing Address _____ Town _____ Postal Code _____

E-Mail Address _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Does Your Child Ride the School Bus? YES NO