Holy Cross School

300 Dubuc Street, Winnipeg, MB, R2H 1E4
Voice (204) 237-4936, Fax (204) 237-7433
Principal acap@holycrossschool.mb.ca

PRE-K APPLICATION FORM

Child's legal last name: _____ Given names: _____

Birthdate: _____/_____/_____ Age: _____ Sex: Male_____ Female_____
dd mm yyyy

Child's address:
Apt# _____ Street# _____ Street_____

City/Town _____ Postal code _____

Phone number _____ Unlisted? Yes ___ No ___ Child's religion _____

PRE-K CLASSES ARE EVERY DAY, MONDAY through FRIDAY FROM 8:30 AM TO 3:00 PM.

Father (Custodial parent___ / Legal Guardian ___) Mother (Custodial parent___ / Legal Guardian ___)

Name:		Name:	
Address:		Address:	
Postal code:		Postal code:	
Home phone:		Home phone:	
Religion:		Religion:	
Occupation:		Occupation:	
Employer:		Employer:	
Business address:		Business address:	
Business phone:		Business phone:	
Cell phone:		Cell phone:	
Email address:		Email address:	

Emergency contact: Address: Phone:		Child's physician: Address: Phone:	
MB Health Number:		PHIN:	

Notes:

Alternates Additional:
Names_____Relationship:_____Phone_____
Names_____Relationship:_____Phone:_____

The following procedures will be taken in case of ACCIDENTS TO CHILDREN:

1. In case of any minor accident or illness, first aid shall be rendered and parents WILL BE NOTIFIED IF AT ALL POSSIBLE for further direction.
2. In case of an accident or illness which, in the opinion or the Director (or staff member), requires immediate medical care, first aid shall be rendered. If the parents CANNOT BE REACHED IMMEDIATELY, the Director (or staff member) will take or arrange for the injured child to be taken to the nearest hospital emergency ward, if it is deemed necessary to do so. The parents shall be notified of such action as soon as possible. Any cost of ambulance service will be the responsibility of the parent/guardian.

Please check one of the following:

____ I agree with the above procedure.
____ I DO NOT agree with the above procedure and wish you to follow the procedure indicated on the bottom of this form.
(***PLEASE NOTE: Every effort is always made to contact parents prior to any action (excluding first-aid). However, if the information we have is not up to date, this could be a problem. Please keep us informed of any changes.)***

_____ _____
Date Parent/Guardian's signature

****

Other procedures: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signing this registration form gives Holy Cross School permission to use your child's picture in promotional advertising, on the web or for school events. Please submit a request in writing to the office should you NOT want your child's picture used for these purposes.

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: HOLY CROSS SCHOOL
❑ School ❑ Licensed child care ❑ Respite ❑ Recreation program	Contact person: Resource
	Phone: 204-237-4936 Fax: 204-237-7433
	Email: secretary@holycrossschool.mb.ca
	Address : Holy Cross School Street: 300 Dubuc Street City/Town: Winnipeg, Manitoba POSTAL CODE: R2H 1E4

Section II - Child information

Last Name **First Name** **Birthdate**

Also Known As

month (print) D D Y Y Y Y

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? _____

❑ **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