HOME AND COMMUNITY CARE SUPPORT SERVICES
Central West

School Health Support Services
Tel: (905) 796-0040
Toll Free: 1-888-733-1177
Fax: (905) 796-4678

APPLICATION FOR SCHOOL HEALTH SUPPORT SERVICES

School Board: ☐ **PDSB** ☐ **DPCDSB** ☐ **UGDSB** ☐ **YRDSB** ☐ **YRCDSB** ☐ **TDSB** ☐ **TCDSB** ☐ **Other**

A. STUDENT INFORMATION

NAME: ____
Print surname, first name

D.O.B.: ____________________ GENDER: ☐ M ☐ F
Day/Month/Year

HOME TELEPHONE: (   ) ____________________ LANGUAGE SPOKEN IN HOME:____________________

ADDRESS: ______________________________________ POSTAL CODE: ____________________

CUSTODIAL PARENT/ GUARDIAN:______________________________________
Print surname, first name

WORK PHONE OR CELL PHONE & RELATIONSHIP: (   ) ______________________________

B. SCHOOL INFORMATION

SCHOOL: ______________________________ BOARD / MINISTRY REGISTRATION: ____________________

ADDRESS: ______________________________TELEPHONE:______________________________

GRADE/CLASS: __________ ☐ Mainstream ☐ Special Ed.: ______________________________
Exceptionality

Individual Education Plan (I.E.P.): ☐ Yes ☐ No

PRINCIPAL: ______________________________ TEACHER: ______________________________
Print surname, first name — Print surname, first name

SCHOOL CONTACT PERSON: ______________________________________
Print surname, first name

C. REASON FOR REFERRAL

DESCRIBE HOW THE STUDENT'S DIFFICULTIES PREVENT PARTICIPATION IN SCHOOL ROUTINE AND RECURRING INSTRUCTION: ☐ **RE-REFERRAL**

____

____

DIAGNOSIS, IF KNOWN____

D. RELEASE OF INFORMATION AND CONSENT TO ASSESSMENT

I do hereby give consent to the School (named above) to release/share information, including Third Party records, relevant to the care and status of my child ______________________________ (student's name) to Home and Community Care Support Services Cenral West as deemed necessary for assessment of School Health Support Services.

I consent to the following:

- Home and Community Care Support Services Cenral West will enter the referral information into its database;
- Home and Community Care Support Services Cenral West will share referral information with their contracted Service Providers;
- The organization and its Service Providers will exchange and share information with School and School Board / School and School Board will exchange and share information with the organization and its Service Providers.

Student's Health Card Number: ______________________________ **Version**:____________________

Student (if over 16 years) or Custodial Parent/Guardian: ______________________________ Date: ____________________

Date: ____________________ Day/Month/Year **Principal's Signature:** ______________________________

The above information is required by tHome and Community Care Support Services Central West in accordance with the Long-Term Care Act, 1994 to determine you or your child/youth's eligibility for organizational services.

As a Home and Community Care Support Services Central West client, you and/or on behalf of your child, have the right to refuse to provide personal information for the purposes explained above. Refusal to provide this information may impact on provision of services. No information is released for any other purpose, without your consent, unless required by law.

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NURSING and DIETETICS REFERRAL CHECKLIST

Student Name: ________________________________ D.O.B. ____________________
Print surname, first name — Day/Month/Year
School Name: ____

Medical Diagnosis: ____

☐ **Nursing:**

- ☐ Injection (intramuscular or intravenous)
- ☐ Respiratory management
  - ☐ Deep suctioning
  - ☐ Tracheostomy care
  - ☐ Percussion/postural drainage
- ☐ G-tube feeds
- ☐ Sterile catheterization
- ☐ Sterile wound care
- ☐ Oxygen – PRN (as required)
- ☐ Education (for newly diagnosed students or students transitioning to new school)
  - ☐ Seizure management
  - ☐ Diabetic management
  - ☐ Clean catheterization
  - ☐ Use of inhalers
- ☐ Other (please specify) ____

☐ **Dietietics:**

- ☐ Management of Enteral tube feeds
- ☐ Management of malnutrition
- ☐ Education re: newly diagnosed or unstable disease process
  Please specify ____
- ☐ Difficulty with swallowing
- ☐ Management of gastrointestinal disorders
- ☐ Other (please specify) ____

Other Relevant Information:

Teacher's Name: ______________________ (Please Print) Signature: ____________________

Date: ______________________________