Form E

Keewatin-Patricia District School Board

REFERRAL
School Health Support Services – (Home Care)

Date:______________________________ School:______________________________

Name:______________________________ Principal:______________________________

D.O.B.:______________________________ Grade:______________________________

Identified Exceptional: Yes ☐ No ☐

New Referral: ☐ Re-Referral: ☐

Parent/Guardian:__________________________________ Phone:__________________

Address:__________________________________ Bus:__________________

Alternate Contact:__________________________________ Phone:__________________

Address:____

Reason(s) for Referral (List educational problem(s) encountered due to disability)

Initiated by:____

Health Support Services Required: [Check appropriate space(s)]

Speech Therapy ☐ Physiotherapy ☐
Occupational Therapy☐ Nursing (please specify) ☐

Principal's Signature: ____

Referral Approved by:__________________________________
(Special Education Department)

I consent to:
1. The provision of School Health Support Services by Home Care Program Service Providers i.e. assessment, treatment and/or training.
2. The release of any information necessary to the provision of that service i.e. Ontario School Record file, Medical and Home Care reports.

______________________________ ______________________________
Parent/Guardian Signature Signature of Witness

FORM F

Keewatin-Patricia District School Board

CONFIRMATION OF TRAINING

Education Support Person ______________________________________, has been trained in the clean catheterization and/or shallow surface suctioning techniques for

_________________________________.

I have observed this procedure being performed correctly by the above-named E.S.P. I feel ___ ______________________________ (Education Assistant) is comfortable and has been observed performing this procedure for up to 10 days, based upon proficiency as determined by the Nursing Service.

Name of Procedure:________________________________

____
Nurse's Signature

____
Date

____
E.S.P.'s Signature

FORM G

Keewatin-Patricia District School Board

Authorization For Performance Of Clean Intermittent Catheterization and/or Shallow Suctioning

Student:	D.O.B.:
Address:	Telephone:
School:	Teacher:

PARENT/GUARDIAN'S APPROVAL

I hereby request and give permission for the performance of clean, intermittent catheterization and/or shallow surface suctioning by a trained Education Assistant to my child at the above school for the lesser of this school year duration, all as set forth by the physician in the form below. I/We understand that I/we are responsible for having the necessary equipment available and that I/we may be required to perform this procedure in special circumstances.

____________________________________ ____________________
Parent/Guardian's Signature Date

PHYSICIAN'S STATEMENT

I hereby certify that the above-named student has a chronic medical condition, which makes him/her unable to attend school safely unless he/she receives the following toileting procedure.

I also certify that the performance of this procedure DURING SCHOOL HOURS is necessary for this child's attendance at school. TO MY KNOWLEDGE, this is a necessary and safe procedure during school hours.

Name/type of procedure:	
Frequency/times to be administered:	
Specialized procedure necessary:	
Anticipated reaction to procedure – possible complications, etc.:	
Health Professional Contact:	Name:
	Position:
	Phone:

____________________________________ ____________________
Physician's Signature Date Signed

____
Address

Note: **Authorization Form must be submitted each school year and whenever the procedure is modified.**

Copies to: **Parent, Physician, Principal/Designate, Student Service**