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 Assistant (E.A.), _____ 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.A.
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 Printed Name

_____
Nurse's Signature

_____
Date

_____
E.A.'s Printed Name

_____
E.A.'s Signature

_____
Date

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 them unable to attend school safely unless they receive 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**