Ontario Health atHome

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 Ontario Health atHome as deemed necessary for assessment of School Health Support Services.

I consent to the following:

- Ontario Health atHome will enter the referral information into its database;
- Ontario Health atHome 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 Ontario Health atHome in accordance with the Long-Term Care Act, 1994 to determine you or your child/youth's eligibility for organizational services.

As a Ontario Health atHome 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: _____ Signature: _____
(Please Print)

Date: _____