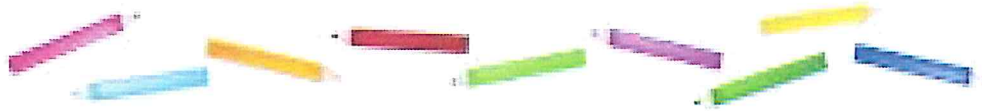




**JUNIOR  
KINDERGARTEN  
PROGRAM  
2018/19**

Turtle River School Division  
Box 309—808 Burrows Ave.  
McCreary MB  
R0J 1B0  
[trsd32.mb.ca](http://trsd32.mb.ca)



**What:** English Junior Kindergarten Program

**Where:** Glenella

**Who:** Children entering Kindergarten in September 2018

**When:** Monday/Wednesday/Friday

Parents can register their child at the Turtle River School Division Office between March and August or at Glenella School beginning September 4, 2017.

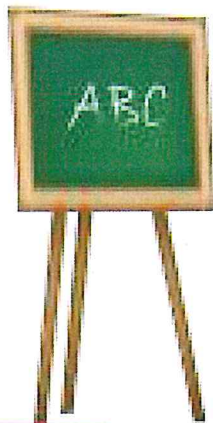
**Turtle River School Division**

Box 309, 808 Burrows Ave.

McCreary MB R0J 1B0

M-F 8:00 am to 3:30 pm

204.835.2067



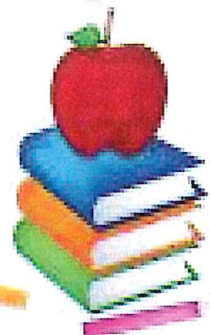
**Glenella School**

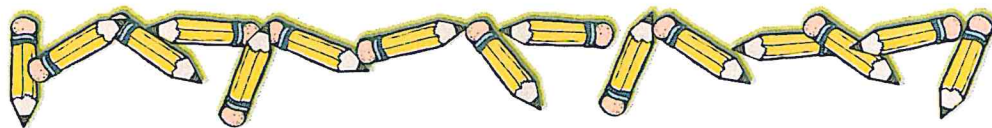
Box 59

Glenella MB R0J 0V0

204.352.4253

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**Junior Kindergarten** is a program in Turtle River School Division that introduces our future kindergarten students to the daily routine of school. It is scheduled for three (3) full days per week (Monday, Wednesday, Friday). The first day of Junior Kindergarten will be **Wednesday, September 6, 2017.**

Activities will include:

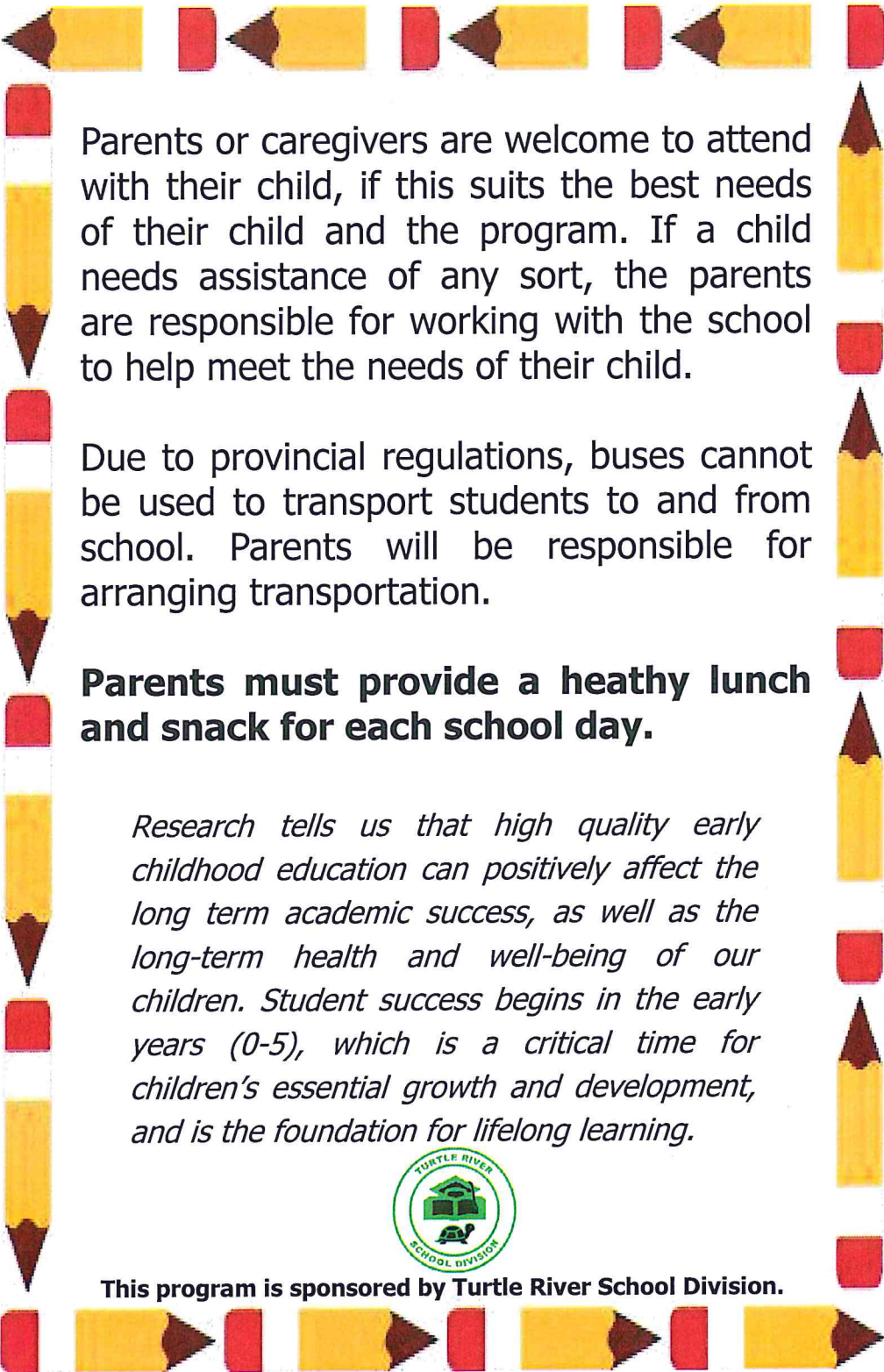
- Circle and story time
- Introduction to academic fundamentals ( letters, shapes, numbers)
- Exposure to the French language and culture
- Social interaction amongst peers and adults
- Free play and movement (gym or playground)
- Fine motor activities (arts, crafts, drawing, puzzles)

Expected Outcomes:

- Introduce parents and child to school environment
- Orientation to classroom routines and expected behaviours
- Improve social skills
- Relieve possible anxieties for starting school







Parents or caregivers are welcome to attend with their child, if this suits the best needs of their child and the program. If a child needs assistance of any sort, the parents are responsible for working with the school to help meet the needs of their child.

Due to provincial regulations, buses cannot be used to transport students to and from school. Parents will be responsible for arranging transportation.

**Parents must provide a healthy lunch and snack for each school day.**

*Research tells us that high quality early childhood education can positively affect the long term academic success, as well as the long-term health and well-being of our children. Student success begins in the early years (0-5), which is a critical time for children's essential growth and development, and is the foundation for lifelong learning.*



**This program is sponsored by Turtle River School Division.**



## Jr. Kindergarten Supply List

- One pair of running shoes for indoor/gym use that they can tie or fasten (label). ☆
- One box of Crayola crayons (16).
- One package of washable markers.
- Two large glue stick.
- One pair of kids scissors.
- Twelve pencils.
- Two erasers (preferably white)
- An old shirt to wear for painting. ☆
- Small plastic water bottle. ☆
- A schoolbag for carrying lunch bag, papers, books, etc. ☆
- Gym clothes (students will change for gym). ☆
- One pair of headphones to wear during computer class. (No earbuds please) ☆

Please label all items that have a star ☆  
beside them.



# Turtle River School Division Policy Statement

Page 2

Section  
Appendix A (ii)

## JUNIOR KINDERGARTEN REGISTRATION

Date of Birth: \_\_\_\_\_ Surname: \_\_\_\_\_ (last).

Given Name(s): \_\_\_\_\_ (first), \_\_\_\_\_ (middle).

Identification Checked by: \_\_\_\_\_ Identification Presented: \_\_\_\_\_  
(Birth Certificate, Baptismal certificate, certificate of live birth, health card, statutory declaration)

Band Name: \_\_\_\_\_ Treaty Number: \_\_\_\_\_

### **Present Address:**

Street or R.R. \_\_\_\_\_ Town: \_\_\_\_\_

P.O. Box # \_\_\_\_\_ Section/Township/Range: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_ Mother's Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Business Phone No: \_\_\_\_\_ Business Phone No: \_\_\_\_\_

Cell No: \_\_\_\_\_ Cell No: \_\_\_\_\_

Email Address: \_\_\_\_\_

Second Email Address: \_\_\_\_\_

List brothers and sisters in order of age: Include preschool children.

| Name  | Date of Birth | School & Grade |
|-------|---------------|----------------|
| _____ | _____         | _____          |
| _____ | _____         | _____          |
| _____ | _____         | _____          |
| _____ | _____         | _____          |
| _____ | _____         | _____          |

Family Doctor: \_\_\_\_\_ Phone No. \_\_\_\_\_

Medical Number(s): \_\_\_\_\_ (6 digit) \_\_\_\_\_ (9 digit)

Any special information or concerns teacher should be aware of:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## STUDENT REGISTRATION FORM

Page 2

### MEDICAL INFORMATION

Manitoba Health Registration No. \_\_\_\_\_ Personal Health I.D. No. \_\_\_\_\_

Health Concerns/Allergies: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

### INDIGENOUS IDENTIFICATION DECLARATION

#### Indigenous Identity Declaration Authorization and Statement of Understanding

*Indigenous Identity Declaration helps to support the efforts of Manitoba Education and Training and school divisions to plan and improve programs in a way that is responsive to Indigenous learners. (Providing this personal information is voluntary and optional. It is being collected in compliance with section 36(1)(b) of The Freedom of Information and Protection of Privacy Act as it is necessary for and relates directly to the activity of Manitoba and school divisions to plan, deliver and improve programs.)*

1. I, \_\_\_\_\_, (name of parent/guardian, please print clearly):
  - ☐ Am submitting my child's Indigenous Identity Declaration for the first time
  - ☐ Am making changes to my child's Indigenous Identity Declaration
  - ☐ Already submitted my child's Indigenous Identity Declaration and have no further changes to make at this time.
  
2. Is your child an Indigenous person, that is, First Nation (North American Indian), Métis, or Inuk (Inuit)? **Note: First Nations (North American Indian) include Status and Non-Status Indians**
  - If "Yes", mark the square(s) that best describe(s) your child now:
    - ☐ Yes, First Nation (North American Indian)
    - ☐ Yes, Métis
    - ☐ Yes, Inuk (Inuit)
  
3. Which best describes your child's Indigenous cultural-linguistic identity?  
Please select up to two choices:
  - ☐ Anishinaabe (Ojibway/Saulteaux)
  - ☐ Ininiw
  - ☐ Dene (Sayisi)
  - ☐ Dakota
  - ☐ Oji-Cree
  - ☐ Michif
  - ☐ Inuktitut
  - ☐ Other-please specify: \_\_\_\_\_



# Declare your child's Indigenous Identity

## Indigenous Identity Declaration (IID)

provides parents and guardians of Indigenous students the opportunity to declare their children's Indigenous identity within Manitoba's school system.

## Why Declare?

- Your declaration helps school divisions enhance services and supports for Indigenous students.
- Providing this personal information is voluntary and optional. Information collected through IID is protected under *The Freedom of Information and Protection of Privacy Act (FIPPA)*.



## Contact Information

For more information about the Indigenous Identity Declaration, please contact your child's school office or the Indigenous Inclusion Directorate at 204-945-1416 or Toll Free in MB at 1-800-282-8069 (ext. 1416).



Indigenous Inclusion  
Directorate

Manitoba 





# Aboriginal Identity Declaration

## Questions and Answers for Parents

### 1. What is Aboriginal Identity Declaration?

Aboriginal Identity Declaration (AID) is an opportunity for parents/guardians of Aboriginal students to declare their child's Aboriginal identity within Manitoba's Kindergarten-Grade 12 public school system. AID information received from parents/guardians is entered into a database by the school office. The information from each school is then reported yearly to the Department of Manitoba Education, Citizenship and Youth.

### 2. Why are Aboriginal students being asked to declare their ancestral/cultural background?

AID information declared by parents/guardians is voluntary.

AID information is needed to support efforts to plan and improve programs. It can help schools/divisions to assess learner and classroom needs and to plan programs to support Aboriginal students.

One of the Department of Education, Citizenship and Youth's goals is to increase high school graduation rates. AID information helps to support this goal. For more information about the Manitoba's goals in relation to Aboriginal education, please visit [http://www.edu.gov.mb.ca/abedu/action\\_plan/index.html](http://www.edu.gov.mb.ca/abedu/action_plan/index.html).

### 3. Statistics Canada collects this information. Why are parents/guardians being asked to provide information to the school?

Statistics Canada collects information about Aboriginal identity based on the Legal Definition of Aboriginal peoples

as identified in the Charter of Rights and Freedoms. It collects information on some Aboriginal languages spoken in the household but it does not typically collect the language and cultural elements. It also gathers this information primarily through the census every 5 years. Census data does not provide the level of detail compared to AID, nor does it provide the data on a yearly basis. The data collected through the AID represents a more complete picture as it is being collected by schools as part of the student registration process.

### 4. I'm a First Nation member and my partner is Metis. Which box do we check?

For families that have multiple ancestral/cultural elements, choose what is most relevant for your family. For more detail, please see the AID identifier descriptions provided on the website at <http://www.edu.gov.mb.ca/aed/abidentity.html>.

### 5. I know I'm Aboriginal but I don't speak any Aboriginal languages. Do I still check any boxes?

Yes. The linguistic identifiers refer to ancestral/cultural identity, not your ability to speak a specific Aboriginal language. Select the identifier(s) that best reflect your identity. If you are still unsure what to choose, you can check the "Other" linguistic category, and write "uncertain" in the space provided.



**6. My child is adopted and Aboriginal, while our family is not Aboriginal. What box do I check?**

You may check the box most appropriate for your child. If you do not know your child's Aboriginal ancestry, you can select "Uncertain of ancestry" from the Aboriginal identifier list.

**7. I moved to Manitoba from another province, and my language is not on the AID list. What box do I check?**

As the list of languages spoken by Aboriginal people in North America is quite large, the AID uses the majority of the languages spoken in Manitoba. If your language is not listed, please check the box labeled "Other". Then you may indicate the language(s) spoken in the space provided (if known, write the language, or if unknown, write "uncertain").

**8. There are so many languages to choose from and my language choice is spelled differently than I remember it being spelled. Are they likely the same?**

Yes. They can be considered the same for the purposes of the AID. There are many different ways of spelling the major language groups. As an example, the word Ojibwe can be spelled, Ojibway and Ojibwa. The same can be said of Inuktituq. It can also be spelled as Inuktitut. Both are considered to be the language spoken by the Inuit people.

**9. I've already declared my child a couple of years ago. Do I need to declare my child every year?**

No. If you have declared your child in the past, you won't need to declare your child every year.

The school office will provide AID information to parents/guardians every year as Aboriginal identity is not assumed. Also, sometimes the information parents/guardians provide the school may need to be updated, such as if a child is new to the public school system, or if changes were made to the list of AID identifiers.

If your child is new to the public school system, or if you need to make a change to the declaration you had previously provided for your child, then a declaration form can be obtained from your child's school office at any time.

**10. We've moved to a different school in a different school division. Do I need to declare my child again?**

No. If parents/guardians have declared their child's Aboriginal identity in the past, the declaration information will remain in the database throughout the child's education in the K-12 public school system.





# Glenella School

Box 59  
Glenella, Manitoba  
R0J 0V0  
204-352-4253



## Home of the Eagles

Principal  
Mr. Nathan Dmytriw  
[ndmytriw@trsd.ca](mailto:ndmytriw@trsd.ca)

Dear Parents,

Please be advised that the Department of Education and Training require that families provide school officials with one piece of valid identification as proof of age/eligibility at the time a student registers for school. Acceptable forms of identification include any of the following:

Birth Certificate

Baptismal Certificate

Certificate of live birth

Health card

Statutory declaration

Thank you for providing these documents.

## UNIFIED REFERRAL AND INTAKE SYSTEM (URIS) GROUP B APPLICATION (a)

### Review application, complete and sign in ink – to be completed **ANNUALLY**.

The purpose of this form is to identify the child's specific health care and if applicable, 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. URIS is a partnership of Health, Education and Family Services. If you have questions about the information requested on this form, you may contact the community program.

#### Section I – To be completed by the community program

|  |   |   |
|--|---|---|
| <b>Type of community program (please ✓)</b><br><br><input type="checkbox"/> School<br><input type="checkbox"/> Licensed child care<br><input type="checkbox"/> Respite<br><input type="checkbox"/> Recreation program<br><input type="checkbox"/> Other: _____ | <b>Community Program Name:</b>  | <b>Location of Service:</b> <input type="checkbox"/> Same as on left                          |
|  | <b>Contact person:</b>  | <b>Contact person:</b>  |
|  | <b>Phone:</b> _____ <b>Fax:</b> _____   | <b>Phone:</b> _____ <b>Fax:</b> _____   |
|  | <b>Email:</b>   | <b>Email:</b>   |
|  | <b>Mailing address:</b><br><b>Street address:</b><br><b>City/Town:</b><br><b>Postal Code:</b> | <b>Mailing address:</b><br><b>Street address:</b><br><b>City/Town:</b><br><b>Postal Code:</b> |

#### Section II - Child information - to be completed by parent

|                               |                      |  |
|-------------------------------|----------------------|--|
| <b>Last Name</b>              | <b>First Name</b>    | <b>Birthdate</b>   |
| <input type="text"/>          | <input type="text"/> | <input type="text"/>   |
|                               |                      | Month (print) D D Y Y Y Y  |
| <b>Preferred Name (Alias)</b> | <b>Age</b>           | <b>Grade</b>   |
| <input type="text"/>          | <input type="text"/> | <input type="text"/>   |
|                               |                      | <b>Gender</b>  |
|                               |                      | <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other |

Does your child ride the bus? ☐ YES ☐ NO

Does your child have any of the following listed health concerns? ☐ YES ☐ NO (check (✓) one)

➤ If you have answered **NO**, please sign here and return this form to the community program.

Parent/Legal Guardian NAME

Parent/Legal Guardian SIGNATURE

DATE (MON/DD/YYYY)

➤ If you have answered **YES**, please complete the remainder of the form **including Section III**.

➤ Please check (✓) all health care conditions for which the child requires an intervention during attendance at the community program. Return the completed form to the community program.

|  |   |
|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | <b>Life-threatening allergy and child is prescribed an injector (e.g. Epi-Pen®/ Taro Epinephrine®/ Allerject®)</b>                |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child bring an injector to the community program?  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | <b>Asthma (administration of medication by inhalation)</b>  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child bring reliever medication (puffer) to the community program?   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does your child know <u>when</u> to take their reliever medication (puffer) e.g. can recognize signs of asthma?                   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Can your child take their reliever medication (puffer) <u>on their own</u> ?  |
|  | IF NO, describe what your child needs help with: _____  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | <b>Seizure disorder What type of seizure(s) does the child have?</b> _____  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child require administration of rescue medication? <input type="checkbox"/> Lorazepam <input type="checkbox"/> Midazolam |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child require the use of a vagal nerve stimulator (wand)?  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | <b>Diabetes What type of diabetes does the child have?</b> <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2        |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child require blood glucose monitoring at the community program?   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child require assistance with blood glucose monitoring?  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child have low blood glucose emergencies that require a response?  |



Unified Referral and Intake System (URIS) Group B Application

|  |   |
|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | <b>Ostomy Care</b>  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child have an ostomy/stoma?  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child require the ostomy pouch to be emptied at the community program?   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child require the established appliance to be changed at the community program?                                  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child require assistance with ostomy care at the community program?  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | <b>Gastrostomy Care</b>   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child have a gastrostomy tube? Type of tube: _____   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child require gastrostomy tube feeding at the community program?   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child require administration of medication via the gastrostomy tube at the program?                              |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | <b>Clean Intermittent Catheterization (CIC)</b>   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child require CIC?   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child require assistance with CIC at the community program?  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | <b>Pre-set Oxygen</b>   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child require pre-set oxygen at the community program?   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child bring oxygen equipment to the community program?   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | <b>Suctioning (oral and/or nasal)</b>   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child require oral and/or nasal suctioning at the community program?   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | Does the child bring suctioning equipment to the community program?   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | <b>Cardiac Condition where the child requires a specialized emergency response at the community program.</b>              |
|  | What type of cardiac condition has the child been diagnosed with? _____   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | <b>Bleeding Disorder (e.g., von Willebrand disease, hemophilia)</b>   |
|  | What type of bleeding disorder has the child been diagnosed with? _____   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | <b>Endocrine Conditions (e.g. steroid dependence, congenital adrenal hyperplasia, hypopituitarism, Addison's disease)</b> |
|  | What type of steroid dependence has the child been diagnosed with? _____  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | <b>Osteogenesis Imperfecta (brittle bone disease)</b> What type? _____  |

**Section III - Authorization for the Release of Medical Information**

In accordance with *The Personal Health Information Act* (PHIA), 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 health care provider, 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:** \_\_\_\_\_ **Child's PHIN:** \_\_\_\_\_

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.

|  |  |                                 |
|--|--|---------------------------------|
| <b>NAME (PRINT) Parent/ Legal Guardian</b> _____ | <b>SIGNATURE Parent/Legal Guardian</b> _____ | <b>DATE (MMM/DD/YYYY)</b> _____ |
| Mailing Address: _____                           | City/Town: _____                             | Postal Code: _____              |
| Work/Daytime Phone: _____                        | Cell Phone: _____                            | Home Phone: _____               |
| Email: _____                                     |  |                                 |



## INDIVIDUAL HEALTH CARE PLAN (IHCP) ASTHMA (2)

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| Name: _____  |  | Birthdate: <u>yyyy/mm/dd</u>  |  | Photo  |  |
| School/Community Program: _____  |  |   |  |  |  |
| Grade: _____   | MHSC: _____  | PHIN: _____   |  |  |  |
| MedicAlert™ bracelet worn?<br><input type="checkbox"/> Yes<br><input type="checkbox"/> No  | Does the child ride the bus?<br><input type="checkbox"/> Yes Bus No. _____<br><input type="checkbox"/> No    |   |  |  |  |
| Parent/Guardian Name: _____  |  | Home Phone No.: _____   | Daytime Phone No.: _____   | Cell Phone No.: _____  |  |
| Parent/Guardian Name: _____  |  | Home Phone No.: _____   | Daytime Phone No.: _____   | Cell Phone No.: _____  |  |
| Alternate emergency contact: _____   |  | Home Phone No.: _____   | Phone No.: _____   | Cell Phone No.: _____  |  |
| Allergist: _____   |  |   | Phone No.: _____   |  |  |
| Pediatrician/Family Doctor: _____  |  |   | Phone No.: _____   |  |  |
| TRIGGERS: List items that most commonly trigger your child's asthma.   |  |   |  |  |  |
| RELIEVER MEDICATION (or bronchodilator) provides fast temporary relief from asthma symptoms. It is recommended that reliever medication is carried with the child so it is available if asthma episode occurs. |  |   |  |  |  |
| What reliever medication has been prescribed for your child? (CHECK ONE)   |  |   |  | <input type="checkbox"/> Salbutamol (e.g. Ventolin®, Novo-Salmol®)<br><input type="checkbox"/> Budesonide (e.g. Symbicort®)<br><input type="checkbox"/> Other: _____ |  |
| How many puffs of reliever medication are prescribed for an asthma episode? (CHECK ONE)  |  |   |  | <input type="checkbox"/> 1 puff <input type="checkbox"/> 1 or 2 puffs<br><input type="checkbox"/> 2 puffs <input type="checkbox"/> Other: _____                      |  |
| Where does your child carry his/her reliever medication?   |  |   |  | <input type="checkbox"/> fanny pack <input type="checkbox"/> purse<br><input type="checkbox"/> backpack <input type="checkbox"/> other _____                         |  |
| Does your child need help when using reliever medication?  |  |   |  | <input type="checkbox"/> Yes What kind of help? _____<br><input type="checkbox"/> No   |  |
| CIRCLE the type of medication device your child uses for <u>reliever medication</u> :  |  |   |  |  |  |
| <br>Metered dose inhaler (MDI)  | <br>MDI with Aerochamber® | <br>MDI with Aerochamber® mask | <br>Turbuhaler® | _____ other  |  |

*The Individual Health Care Plan and emergency medication should accompany the child on excursions outside the facility.*

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

PHIN: \_\_\_\_\_

Individual Health Care Plan - Asthma (Page 2 of 2)

## STANDARD HEALTH CARE PLAN (SHCP) ASTHMA

| IF YOU SEE THIS:   | DO THIS:  |
|--|---|
| <p><b><u>Signs of an asthma episode:</u></b></p> <ul style="list-style-type: none"> <li>▪ Coughing</li> <li>▪ Wheezing</li> <li>▪ Chest tightness</li> <li>▪ Shortness of breath</li> <li>▪ Increase in rate of breathing</li> </ul>   | <ol style="list-style-type: none"> <li>1. Remove the child from triggers of asthma (e.g. exercise, cold air, smoke).</li> <li>2. Have child sit down.</li> <li>3. Ensure the child takes reliever medication (blue cap).</li> <li>4. Encourage slow deep breathing.</li> <li>5. Monitor child for improvement.</li> </ol> |
| <p><b><u>Emergency Situations:</u></b></p> <ul style="list-style-type: none"> <li>▪ Reliever medication has been given and there is no improvement of asthma symptoms in 5 minutes</li> <li>▪ Greyish/bluish color in lips and nail beds</li> <li>▪ Inability to speak in full sentences</li> <li>▪ Heaving of chest or chest sucking inward</li> <li>▪ Shoulders held high, tight neck muscles</li> <li>▪ Cannot stop coughing</li> <li>▪ Difficulty walking</li> </ul> <p>If asthma symptoms are severe, the child may NOT be wheezing as there is not enough air moving in the lungs to generate a wheeze.</p>  | <ol style="list-style-type: none"> <li>1. Activate 911/EMS.</li> <li>2. Give reliever medication every 5 minutes.</li> <li>3. Notify parent/guardian.</li> <li>4. Stay with child until EMS personnel arrives</li> </ol>  |
| <p><b><u>Signs that asthma is not controlled</u></b></p> <p><b>If staff become aware of any of the following situations, they should inform the child's parent/guardian.</b></p> <ul style="list-style-type: none"> <li>▪ Asthma symptoms prevent child from performing normal activities.</li> <li>▪ Child appears to be experiencing more frequent coughing, shortness of breath or wheezing.</li> <li>▪ Child is using reliever medication more than 3 times per week to relieve asthma symptoms. An exception to this includes the use of reliever medication before exercise to prevent exercise induced asthma symptoms, which then may be used up to once a day.</li> </ul> |   |

*I have reviewed the above plan for my child and provide consent to this plan on behalf of my child.*

**Parent/guardian signature:** \_\_\_\_\_ **Date:** yyyy/mm/dd

*I have reviewed the above plan to ensure it provides the community program with required information.*

**Nurse signature:** \_\_\_\_\_ **Date:** yyyy/mm/dd

*I have received the above plan and have notified appropriate staff.*

**Program Designate signature:** \_\_\_\_\_ **Date:** yyyy/mm/dd

☐ Instruction sheet for medication device attached

**FOR OFFICE USE ONLY:**

|  |  |
|--|--|
|  |  |
|  |  |


## ANAPHYLAXIS INDIVIDUALIZED HEALTH CARE PLAN

|  |  |  |   |
|--|--|--|---|
| Child name:  |  | Birth date:  |   |
| Community program name:  |  | MedicAlert™ identification worn ?  |   |
| Grade:   |  | <input type="checkbox"/> YES <input type="checkbox"/> NO                             |   |
| Parent/guardian name:  |  |  |   |
| Home #:  | Cell #:  | Work #:  |   |
| Parent/guardian name:  |  |  |   |
| Home #:  | Cell #:  | Work #:  |   |
| Alternate emergency contact name:  |  |  |   |
| Home #:  | Cell #:  | Work #:  |   |
| Allergist:   |  | Phone #:   |   |
| Pediatrician/Family doctor:  |  | Phone #:   |   |
| Life-threatening allergens   |  |  |   |
| Other allergies (non life-threatening):  |  |  |   |
| <b>Adrenaline auto-injector prescribed for child</b>   | <b>Type of device</b><br><input type="checkbox"/> EpiPen®<br><input type="checkbox"/> Allerject™ | <b>Dosage</b><br><input type="checkbox"/> 0.3 mg<br><input type="checkbox"/> 0.15 mg | <b>Location</b><br><input type="checkbox"/> Fanny pack or belt<br><input type="checkbox"/> Backpack<br><input type="checkbox"/> Purse<br><input type="checkbox"/> Other _____ |
| It is recommended that the adrenaline auto-injector is with the child during attendance at the community program. Antihistamines are NOT used in the management of life-threatening allergies in community program settings. |  |  |   |
| Child has a back-up adrenaline auto-injector at the community program. <span style="float: right;"> <input type="checkbox"/> YES Location _____<br/> <input type="checkbox"/> NO         </span>                             |  |  |   |
| <b>OTHER INFORMATION ABOUT MY CHILD'S LIFE THREATENING ALLERGY THAT THE COMMUNITY PROGRAM SHOULD KNOW:</b>   |  |  |   |

The Health Care Plan and emergency medication should accompany the child on excursions outside the facility.



## ANAPHYLAXIS EMERGENCY RESPONSE PLAN

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| Name:   | Birth date:  |   |  |  |   |
| <b>IF YOU SEE THIS</b> <div style="text-align: center; margin: 10px 0;">  </div>   | <b>DO THIS</b>   |   |  |  |   |
| <p><b><u>If ANY combination of the following signs is present and there is reason to suspect anaphylaxis:</u></b></p> <p><i>When remembering the signs of anaphylaxis, think F.A.S.T (Face, Airway, Stomach, Total Body)</i></p> <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <b>Face</b> <ul style="list-style-type: none"> <li>red watering eyes</li> <li>runny nose</li> <li>itchiness</li> <li>redness, swelling of face, lips &amp; tongue</li> </ul> </td> <td style="width: 50%; vertical-align: top;"> <b>Stomach</b> <ul style="list-style-type: none"> <li>vomiting</li> <li>diarrhea</li> <li>cramps</li> </ul> </td> </tr> <tr> <td style="vertical-align: top;"> <b>Airway</b> <ul style="list-style-type: none"> <li>throat tightness</li> <li>change of voice</li> <li>difficulty swallowing</li> <li>difficulty breathing</li> <li>coughing</li> <li>wheezing</li> </ul> </td> <td style="vertical-align: top;"> <b>Total body</b> <ul style="list-style-type: none"> <li>swelling</li> <li>hives</li> <li>itchiness</li> <li>sense of doom</li> <li>change in behavior</li> <li>pale or bluish skin</li> <li>dizziness</li> <li>fainting</li> <li>loss of consciousness</li> </ul> </td> </tr> </table> | <b>Face</b> <ul style="list-style-type: none"> <li>red watering eyes</li> <li>runny nose</li> <li>itchiness</li> <li>redness, swelling of face, lips &amp; tongue</li> </ul>   | <b>Stomach</b> <ul style="list-style-type: none"> <li>vomiting</li> <li>diarrhea</li> <li>cramps</li> </ul> | <b>Airway</b> <ul style="list-style-type: none"> <li>throat tightness</li> <li>change of voice</li> <li>difficulty swallowing</li> <li>difficulty breathing</li> <li>coughing</li> <li>wheezing</li> </ul> | <b>Total body</b> <ul style="list-style-type: none"> <li>swelling</li> <li>hives</li> <li>itchiness</li> <li>sense of doom</li> <li>change in behavior</li> <li>pale or bluish skin</li> <li>dizziness</li> <li>fainting</li> <li>loss of consciousness</li> </ul> | <ol style="list-style-type: none"> <li>1. Give adrenaline auto-injector (EpiPen or Allerject).               <ol style="list-style-type: none"> <li>Secure child's leg.</li> <li>Identify site on outer middle thigh.</li> <li>Grasp adrenaline auto-injector in fist and remove safety cap(s).</li> <li>Firmly press tip into the thigh at a 90° angle until you hear a click.</li> <li>Hold in place for a slow count of 5.</li> </ol> </li> <li>2. Activate 911/EMS.</li> <li>3. Notify parent/guardian.</li> <li>4. If signs of anaphylaxis persist or recur, give backup adrenaline auto-injector (if available) every 5 to 15 minutes.</li> <li>5. Stay with child until EMS personnel arrive.</li> <li>6. Discard adrenaline auto-injector safely or give to EMS personnel.</li> </ol> |
| <b>Face</b> <ul style="list-style-type: none"> <li>red watering eyes</li> <li>runny nose</li> <li>itchiness</li> <li>redness, swelling of face, lips &amp; tongue</li> </ul>  | <b>Stomach</b> <ul style="list-style-type: none"> <li>vomiting</li> <li>diarrhea</li> <li>cramps</li> </ul>  |   |  |  |   |
| <b>Airway</b> <ul style="list-style-type: none"> <li>throat tightness</li> <li>change of voice</li> <li>difficulty swallowing</li> <li>difficulty breathing</li> <li>coughing</li> <li>wheezing</li> </ul>  | <b>Total body</b> <ul style="list-style-type: none"> <li>swelling</li> <li>hives</li> <li>itchiness</li> <li>sense of doom</li> <li>change in behavior</li> <li>pale or bluish skin</li> <li>dizziness</li> <li>fainting</li> <li>loss of consciousness</li> </ul> |   |  |  |   |
| <p><b><u>Risk reduction strategies</u></b> are the only way to prevent anaphylaxis. Although it is not possible to achieve complete avoidance of allergens in community program settings, it is important to reduce exposure to life-threatening allergen(s). Please contact the community program if you have any questions about the risk reduction strategies that are implemented in their facility. School division policy may be found on their website.</p>  |  |   |  |  |   |

*I have reviewed the above plan for my child and provide consent to this plan on behalf of my child.*

**Parent/guardian signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*I have reviewed the above plan to ensure it provides the community program with required information.*

**Nurse signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Documentation**

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## RESPONSIBILITY OF FAMILIES

- Inform the community program of any medical or special health care needs of your child.
- Complete the URIS Group B Application form provided by the community program.
- Talk with the URIS Nurse to develop your child's individual health care plan for the community program.
- Sign your child's completed health care plan for use at the community program.
- Inform the staff at the community program as well as the URIS nurse of ANY changes to your child's health information at any time.

FOR MORE  
INFORMATION OR TO  
APPLY FOR URIS  
SUPPORT, CONTACT  
YOUR COMMUNITY  
PROGRAM



Date of Issue: April 2014  
Date of Revision: May 2014  
Document #: PMH149



## UNIFIED REFERRAL AND INTAKE SYSTEM (URIS) A GUIDE FOR PARENTS

[www.prairiemountainhealth.ca](http://www.prairiemountainhealth.ca)



# Unified Referral and Intake System (URIS)

The URIS program supports children who require assistance with health care needs while attending community programs including schools, licensed child care facilities, respite services, and recreation programs within Prairie Mountain Health.

With your assistance, the URIS Nurse will complete an Individual Health Care Plan for your child

This Health Care Plan outlines your child's health history and the necessary interventions to support your child's health care needs while attending the community program.

The URIS Nurse will train the community program staff for procedures specific to your child's health care need (eg. how to administer an inhaled medication to a child with Asthma).

URIS training supports schools, licensed child care facilities, recreation programs and respite services personnel to respond to your child's specific health care needs and emergencies.

Prairie Mountain Health URIS Program partners with Manitoba health care professionals to ensure your child is receiving the best support available.



The Unified Referral and Intake System (URIS) is a partnership of Prairie Mountain Health and the Government of Manitoba Departments of Health, Family Services and Education

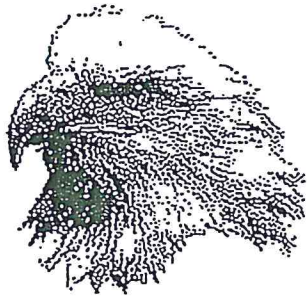


## Health Care Conditions (Group B)

Health care procedures may be safely delegated to non-healthcare personnel when the child's health status is stable and response to the procedure is predictable. Non-healthcare personnel must receive training and ongoing monitoring by a URIS Nurse. The URIS program may provide support for the following conditions:

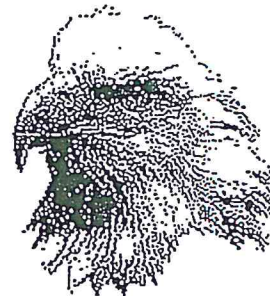
- Life-threatening Allergy (anaphylaxis)
- Asthma (when medication is present at the community program)
- Seizure Disorder
- Diabetes
- Cardiac Condition
- Bleeding Disorder
- Steroid Dependence
- Osteogenesis Imperfecta (brittle bone disease)
- Gastrostomy Care and Feeding
- Ostomy Care
- Clean Intermittent Catheterization (IMC)
- Pre-set Oxygen
- Suctioning (oral and/or nasal)
- Administration of Medications





# Glenella School

Box 59  
Glenella, Manitoba  
R0J 0V0  
204-352-4253



Home of the Eagles

Dear Parents:

## Reminder of the Food Allergy Notice:

We have students and staff at Glenella School who have food allergies. We have a number of people who are severely allergic to **peanuts, tree nuts, mangos and shellfish**. Exposure to even extremely small amounts of these items is extremely dangerous and life-threatening. Mangos are included in the cashew family, so please be considerate when you are packing your child's lunch to not pack a mango or even the fruit cups that have mangos in them.

We ask all parents to help us to prevent these children being exposed to peanut, tree nut or shell fish products, by checking that food products sent with your child to school does NOT contain any peanut, tree nut or fish products. Tuna and salmon is not a shellfish product and is permitted. Also, **please discourage your own child or children from sharing his or her lunches or snacks while at school**. Please follow the safe Food Snack list that was in the school registration package.

We realize this may be an inconvenience to you, but ask that you respect this notice. Please feel free to contact me at the school if you require further information regarding this notice.



## Peanut Free Snack Ideas



**Quaker** – Rice cakes (Caramel, corn, apple cinnamon, white cheddar, original ranch, taco, crunchy dill, BBQ, sour cream & onion) Granola bars, large assortment labelled peanut free. Instant oatmeal. **Nature Valley** has also come out with Chewy Chocolate Chip Bars. Please always remember to watch for Peanut Free Symbol with these products.

**Betty Crocker** – Dunkaroos, Fruit roll ups, Gushers, Fruit by the foot, Lucky Charms fruit snack, Scooby-Doo fruit snacks, Sodalicious, Mickey Mouse peel outs or Princess rolls. Betty Crocker Cake mixes, and Icings are safe.

**Kelloggs** – Nutrigrain bars, and twists, pop Tarts, Rice Crispie squares (Original, chocolate & Caramel) Yogos fruit loop snacks. Variety of cereals including, Chex, Cinnamon Toast Crunch, Fruit Loops, Corn Pops, Corn Flakes, Crispex, Frosted Flakes, Frosted mini-wheats, Shredded Wheat, Life (Original) Rice Krispies.

**Christie Crackers** – Crispers (Original, BBQ, ranch, salt & vinegar, All dressed ). Premium Plus Saltines, Oat Thins, Wheat Thins, Stoned Wheat Thins, Bacon Dippers, Cheese Bits, Socialbles, Swiss Cheese, Vegetable Thins, Triscuit (Original only). Ritz Original

**Cookies** – Chips Ahoy, Chunks Ahoy, Chewy Chips Ahoy, Teddy Grahams, Fudgee-O (Regular, and double stuffed) Oreo (Original) Arrowroot, Bear Paws, Viva Puffs, Wagon Wheels, Dare Cookies, large assortment including Ruffles, Maple, Banana Cream, Coconut Cream. Snack packs, mini oreos, chocolate chip, animal crackers, teddy grahams, All by Christie.

**No Name (Yellow and Black label)** – Zoo animal fruit snacks, Cheddar Cheese Snack Crackers, Fruit Rolls, Sugar Wafers, Rice Cakes, Ginger Snaps, Puddings, Fruit Cups, Shortbread Cookies, Social Tea Biscuits, Honey Grahams. **Note that new products will always become available, just watch for the Peanut free Logo**

**Presidents Choice** – Crisp and Thin Crackers, Woven Wheats, Rice Cakes, Peppercorn Ranch Chippers, Fruit Bars. Mr Mini cookies, Granola bars (Dipped, and Chewy, or Regular Chocolate chip)

**Miscellaneous** – Dempsters Bagels, w/cream cheese. Pillsbury Baking tubes, including biscuits, pie crusts, cinnamon rolls, cookies. Dempsters Tortillas wraps, Original, whole wheat, vegetable. Fresh Fruit, with the exceptions of **Mangos** or **Kiwii**. Caramel dip for apples, Veggies & Dip, SunMaid Raisins, or Apricots, Yogurt, Cheese Strings, or Curds. Kraft Handi Snacks crackers or breadsticks with cheese.

Motts Fruitsations, fruit cups, Jell-o, Puddings, Popcorn (Pop Secret, Orville Redenbacher, Healthy Choice), Pretzels (Rold Gold, or Old Dutch) Potato Chips, (Old Dutch, Lays, Doritos, Ruffles, Cheetos, Tostitos, Pringles Original) Pizza (Dominoes, Pizza Hut, and Papa Johns, all safe)

**Chocolate & Candy** – Smarties, Coffee Crisp, Aero, Kit Kat, Mars. Nestle Mini Rolo. Ice cream – Chapmans Peanut Free, large variety. Mr Freeze and Crush Freezies.

- ♦ Mike and Ikes
- ♦ Wonka's Nerds & Nerds Rope
- ♦ Laffy Taffy
- ♦ Runts
- ♦ Dubble Bubble gum
- ♦ Tootsie Pops & Tootsie Rolls (*anything made by Tootsie*)
- ♦ Junior Mints
- ♦ Lifesaver Gummies
- ♦ Smarties
- ♦ Sour Patch Kids – all varieties
- ♦ Whoppers
- ♦ Sweet Tarts
- ♦ Hot Tamales
- ♦ Red Vines
- ♦ Jolly Rancher hard candy, lollipops and gummi candy
- ♦ Twizzlers
- ♦ Rolos (minis)
- ♦ Starburst fruit chew, lollipops
- ♦ Kraft Marshmallows

**Safe Oils** – Canola, Sunflower, Cottonseed, and Vegetable

Due to continual changes in manufacturer packaging and processing, please always check labels to ensure it does not contain any of the following, peanuts/tree nuts, peanut flour, peanut oil, peanut meal. Or for any of these statements, ***May contain traces of peanuts/tree nuts, or Manufactured in a facility that also processes nuts.***

**\*ANY product from a Bulk store or Bin IS NOT SAFE!**

<https://www.facebook.com/groups/safesnackideas/>