VANCOUVER BOARD OF EDUCATION

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Student's Name _____
SURNAME FIRST NAME

Birthdate _____
YEAR MONTH DAY

School _____

I authorize the Vancouver School Board to hereby:

- ☐ Obtain information and/or records from other appropriate agencies.
- ☐ Release information and/or records on a strictly confidential basis to other appropriate agencies.
- ☐ Discuss pertinent information with representatives from appropriate agencies on a strictly confidential basis.

I request the Vancouver School Board to:

- ☐ Release copies of VSB Psychological/Speech Language Pathology Assessment to me.

Please note that if your son/daughter transfers to another school or district, all reports will be sent to that school/district.

Address _____

Postal Code ☐☐☐ ☐☐☐ Telephone Number _____

Parent/Guardian Signature _____ Date _____

Vancouver Paediatric Team
2110 West 43rd Avenue
Vancouver, BC Canada V6M 2E1
Telephone (604) 267-2606
Facsimile (604) 261-7220

Vancouver Paediatric Team Consent Form

Child's Name: _____ Date of Birth: _____

The Vancouver Coastal Health (VCH) Paediatric Team (VPT) helps children with special health care needs lead active, healthy lives in their homes, schools and communities. Our Paediatric Team of community health nurses, occupational therapists, physiotherapists and social workers provide one or more of the following:

- School-based consultation for children aged 5 to 19.
- Short-term therapy for children discharged from hospital.
- Assistance to children with complex medical nursing needs.
- Assistance to children and families who need palliative care.
- Assistance to children 0 to 5 years old who have feeding issues.

To provide necessary services to your child, a Paediatric Team member may consult and work with you and others including school staff, family physician, other hospitals, agencies and health care providers (including those hired by you or your family to work with your child) who may also be involved in providing for your child's health, development and general well-being.

For example, a team member may interview parents and teachers and gather information about your child's medical condition from various other agencies and health care providers in order to assess your child's needs. This may also involve taking photographs for illustration purposes, doing formal and informal assessments and trialing specialized equipment. Based on the assessment, a child-specific health care plan is developed to address his or her needs. We may share this health care plan and offer training to you as well as with teachers and other care providers who may also be involved in caring for your child.

Where a child may require specialized equipment, we may also assist you in obtaining funding for such equipment through programs offered by various government or other agencies, such as the Ministry of Children and Family Development or Ministry of Social Development and Social Innovation. To do so, we may have to complete necessary application forms and provide these agencies with the required information about your child in order for him or her to receive benefits under such programs.

By signing below, you authorize VCH to collect, use and share information about your child as described above for purposes of the Paediatric Team providing services to your child. VCH collects uses and shares personal information only in accordance with the BC *Freedom of Information and Protection of Privacy Act*.

You may withdraw your consent at any time by contacting the VCH Vancouver Paediatric Team.

_____ _____
Signature Date

_____ _____
Print Name of Parent/Guardian Address

Please contact the VCH Information Privacy Office at (604) 875-5568 or email: privacy@vch.ca if you have any questions about your privacy.

Vancouver Paediatric Team
2110 W. 43rd Avenue, Vancouver, BC V6M 2E1
Telephone: (604) 267 – 2606 Fax: (604) 261 - 7220

Physiotherapy Referral

Please complete all sections. Incomplete fields may delay the processing of this referral.

DATE:	☐ **Attach PRIS form related to this referral**
STUDENT NAME:	DATE OF BIRTH (DD/MM/YYYY):
PREFFERED NAME:	GENDER: ☐ M ☐ F ☐ _____
ABORIGINAL STATUS: ☐ Yes ☐ No ☐ Unknown	PERSONAL HEALTH NUMBER:
DIAGNOSIS/MEDICAL HISTORY:	
MINISTRY DESIGNATION:	GRADE:
STUDENT WEARS GLASSES: ☐ Yes ☐ No	STUDENT WEARS HEARING AIDS: ☐ Yes ☐ No
BEHAVIOURAL PLAN in place: ☐ Yes ☐ No	EMPLOYEE SAFETY PLAN in place: ☐ Yes ☐ No
FORM COMPLETED BY:	POSITION:
SCHOOL: TELEPHONE: EMAIL:	
SSA SUPPORT (Describe):	
IEP: ☐ Yes ☐ No Attached: ☐ Yes ☐ No	

GUARDIAN 1:	GUARDIAN 2:
RELATIONSHIP to Student:	RELATIONSHIP to Student:
ADDRESS:	ADDRESS (If different):
POSTAL CODE:	POSTAL CODE (If different):
TELEPHONE (Home): (Cell): (Work):	TELEPHONE (Home): (Cell): (Work):
EMAIL:	EMAIL:
LANGUAGE SPOKEN AT HOME:	INTERPRETER REQUIRED: ☐ Yes ☐ No

FAMILY PHYSICIAN:	TELEPHONE:
ADDRESS:	

ASSESSMENTS/CONSULTATIONS BY OTHER PROFESSIONALS:

	Completed	Waitlisted	Contact Person/Agency	Telephone	Date
Paediatrician	☐	☐			
SHHC Clinic(s) e.g. CDBC, PARC	☐	☐			
Psychologist	☐	☐			
SLP	☐	☐			
OT	☐	☐			
PT	☐	☐			
Nurse	☐	☐			
Other:	☐	☐			

*****PLEASE ATTACH RELEVANT REPORTS *****

STUDENT: _____ DATE OF BIRTH (DDMMYYYY): _____

PHYSIOTHERAPY REFERRAL INFORMATION

GROSS MOTOR SKILLS (Please tick √ if there are any concerns):

In comparison to their peers:	√
Does the student appear to have an unusual walking style? If yes, describe below.	
Do the student's movements appear ☐ clumsy, ☐ awkward, and/or ☐ uncoordinated?	
Does the student appear to have unexpected weakness?	
Student has difficulty ☐ throwing, ☐ catching, ☐ kicking (ball), ☐ jumping, ☐ hopping, ☐ skipping	
Student falls down more frequently than expected	
Student has difficulty walking on uneven terrain	
Student has difficult playing on playground equipment	
Student has difficult ☐ going up and/or ☐ going down stairs	
Student has difficulty getting up from the floor	
Student has decreased safety awareness or has safety concerns. If yes, describe below.	
Does the student use any equipment? ☐ walker ☐ wheelchair ☐ other:	
Does the student wear any foot ☐ orthotics or ☐ splints?	
Please provide further information for any "yes" answers:	

REASON FOR REFERRAL (Please indicate all that applies below and describe in detail):

☐ SAFETY (Consider potential injury to student or musculo-skeletal injury to staff related to falls, transfers, or stairs):
☐ MOBILITY/ACCESS ISSUES: ☐ Inside classroom ☐ Outside classroom ☐ On playground ☐ In PE class ☐ In washroom. Please describe:
☐ EQUIPMENT NEEDS (Please list any additional equipment related to mobility, transfers or physical access that the student requires within the school environment):
☐ EXPECTED OUTCOME OF REFERRAL (E.g. Individualized exercise program; PE modifications; etc):
☐ PRIMARY CONCERNS/GOALS OF FAMILY:

Please fax/bluebag via VSB internal mail, the completed forms and all attachments including the VPT and VSB consent forms to the contact details listed on front page of this form.

Please complete all sections. Incomplete fields may delay the processing of this referral.