Visitation and Family Access

Revised April 2018

Client:	
Program:	

Instructions at Admission:

Visit Schedule & Telephone Contact:

Signature of Guardian: _____

Date: _____

Consent to Administer a Psychotropic Drug

Revised December 2018

To be completed by Parent/Therapist/Staff when a psychotropic medication is prescribed, when there is a dosage change, or when a medication is discontinued. A complete update of this form will be also required yearly in October for each client receiving Psychotropic medication.

Client's Name:_____(DOB):_____

Date of Consultation (mm/dd/yyyy): _____

To be completed by the Prescribing Physician:

Working Diagnostic Formulation:_____

Medication:_____ Dose:_____

1. The agreed upon target symptoms for this medication (purpose of the medication) include:
    1. _____
    2. _____
2. The risks and side effects for this medication are explained in the Compendium of Pharmaceuticals and Specialties (CPS). The reviewed clinically relevant side effects for this client are:

    _____

    _____
3. The medication will be given (frequency) _____for (duration)_____

Doctor's Signature:_____Telephone #:_____

Date of Prescription:_____Follow-Up In:

Acknowledgment of the Parent/Therapist/Staff

On the above date the reasons for the medication, the dosing schedule and the relevant side effects were explained to me. I understand how to contact the prescribing physician, contact the dispensing pharmacy, and/or use http://www.webmd.com/drugs/index-drugs.aspx if I have any concerns surrounding this medication.

Parent/Therapist's/Staff Signature:_____ Date:_____

Acknowledgment of the Client

On the above date the reasons for the medication, the dosing schedule and the relevant side effects were explained to me in terms I understand. Further, I know that I can discuss with my Parent/Therapist, can contact the prescribing physician, and/or the dispensing pharmacy if I have any concerns surrounding this medication.

I agree to take this medication as prescribed until I discuss it with the prescribing physician.

Client's Signature:_____Date_____

Parent/Guardian/Agency Consent for Administration

The above medical recommendation has been reviewed and I understand how to contact the prescribing physician, the dispensing pharmacy and/or use http://www.webmd.com/drugs/index-drugs.aspx if I have any concerns surrounding this medication.

I am satisfied that I am aware of the risk, benefits of this medication and am aware that this consent can be withdrawn at anytime through contact with the prescribing physician, who would safely withdraw this medication from the client's treatment plan.

Consent is (please check): Provided ☐ **Declined** ☐

Parent/Guardian/Agency:_____Date_____

Acknowledgement of Risk Levels Involving Restraint

Revised April 2018

Template Owner:	SWA Programs
Template Used By:	Parent Therapist, Staff, Program Supervisor, Program Coordinator
Template Purpose:	Form to determine the possible risk of harm to a client during a physical hold and to address the likelihood that physical holding would be necessary to ensure the safety of the client and others **Note- Risk Assessment to* be completed at intake and at each POC.

Name: _____ **Date:** _____

Physical Restraints are only used as a response to immediate safety concerns and not as "therapeutic holding"

Chart #1 is used to determine the possible risk of harm to a client during physical holding.
Chart #2 is used to determine the likelihood that physical holding will be necessary for this client. Caregivers should note that the following charts are only a guideline, and thus, in every circumstance vigilance in monitoring should be imposed. Prior to any physical holding, alternative efforts will be made to de-escalate the client.

CHECK THE APPLICABLE ITEM(S)

*Chart #1 Risk of **Injury** to Client*	*Chart #2 Potential for the need to **Restrain***
Primary Factors ☐ Mania ☐ Obesity ☐ Respiratory syndromes including ☐ Asthma and Bronchitis (x2) ☐ Cardiovascular disorders (x2) ☐ Use of neuroleptic/stimulant medication ☐ Racial Characteristics ☐ Large Stature ***Secondary Factors*** ☐ Position of restraint (e.g. prone) (x2) ☐ Prolonged Struggle (e.g., > 15 minutes) (x2) ☐ Drug/alcohol intoxication ***Total number of factors=*** (Ensure that those factors marked X2 are added twice)	☐ Hx of previous restraints ☐ none=0; few=2; many=4 ☐ Hx of previous aggression ☐ none =0; few=2; many =4 ☐ (if 0 then skip next question) ☐ Seriousness of previous aggression ☐ minor=1; moderate=3; serious=5 ☐ Mood instability ☐ none-0; some=1; serious=2 ☐ Impulsivity ☐ none=0; some=1; serious=2 ☐ Hx of self-harm ☐ none=0; minor=1; serious=2 ☐ School maladjustment ☐ none=0; minor=1; serious=2 ☐ Interpersonal difficulties ☐ none=0; few=1; many=2 ***Total Score=***

	Low 0-8	High >8
Low 0-4	***A***	**B**
High 5-10	**C**	**D**

A Low risk of injury; Low probability of restraint-utilize standard protocol for restraints.

B Low risk of injury; high probability of restraint-increase observation re: safety and security, proactive treatment (e.g., medication, relationship building, and skills development)

C High risk of injury; Low probability of restraint- re-evaluate risk frequently; ensure vigilant monitoring if restraint occurs; provide as much leeway as possible with respect to de-escalation; utilize two staff for restraints.

D High risk of injury; High probability of restraint- re-evaluate risk frequently: informed consent of restraint to be received by all interested parties; vigilant in monitoring restraints: insure two staff available for restraints; increase observation re: safety and security, proactive treatment (e.g., medication, relationship building, skills development, and one to one staffing).

Signature of SWA/QCH/AAPL rep; _____

Signature of Parent/Guardian/CAS rep: _____

Signature of Client: _____

Additional Information

Related Documents

- ASQ-IT

Consent for Release/Receiving of Information

Revised February 2019

Release of Information

I, _____ D.O.B_____give permission to:

(myself, my child under sixteen years of age) **mm/dd/yyyy**

☐ Stevenson, Waplak & Associates ☐ Quinte Childrens Homes ☐ BridgeCross ☐ Applewood Academy ☐ Other

to receive information from: **(Please check off all that apply)**

_____ a. School _____
Name of School/Board

_____ b. Police _____
Name of Police (i.e OPP, City Police, RCMP, etc.)

_____ c. Physician _____
Name and address of Doctor

_____ d. Public Health Agency _____
Name and address

_____ e. Children's Aid Society _____
Name and Address

_____ f. Other _____
Name and Address

To share written or verbal information regarding (specify name of client/D.O.B/Brief description of Information being sought)

_____

_____

Receiving of information

I, _____D.O.B_____give permission to:

(myself, my child under sixteen years of age) mm dd/vvvv

☐ Stevenson, Waplak & Associates ☐ Quinte Childrens Homes ☐ BridgeCross ☐ Applewood Academy ☐ Other

to release information to: **(Please check off all that apply)**

_____ a. School _____
Name of School/Board

_____ b. Police _____
Name of Police (i.e OPP, City Police, RCMP, etc.)

_____ c. Physician _____
Name and address of Doctor

_____ d. Public Health Agency _____
Name and address

_____ e. Children's Aid Society _____

_____ f. Other _____
Name and address

To share written or verbal information regarding _____
(specify name of client/D.O.B/Brief description of Information being sought)

I understand that:

a) I may revoke my consent at any time.

b) Information gathered will be treated confidentially.

c) Information will be used for purposes of planning for and providing for and providing services for my child and family

Information will not be released to any other third party without my permission unless:

a) I or my child have indicated that there is risk of harm occurring to me or my family or another person, or there is a disclosure of harm done to me, my family or another person.

b) My life is subpoenaed or otherwise subject to review by legislation.

This Consent Valid until _____
(month/day/year)

My Signature verifies that this consent has been explained to my satisfaction and is clearly understood by me.

_____ _____
Legal guardian of client under 16 years of age Client (12 years of age or over)

_____ _____
Relationship to client Witness

***Copy to each initialled organization**

Authorization would be revoked if request for information occurred beyond the end date indicated on the form or should an individual wish to revoke release or receipt of information they would contact the office. The individual that requires the completion of the form will ensure consent is revoked. This will be noted in the clients file and on the actual document indicated by client signature.

HASTINGS PRINCE EDWARD
Public Health

School Immunization History

TO BE COMPLETED AT TIME OF REGISTRATION

Hastings Prince Edward Public Health (HPEPH) is required under the *Immunization of School Pupils Act* (ISPA) to collect and maintain up-to-date records of immunization for every child registered in school in Hastings and Prince Edward counties. **The ISPA states that parents are required to provide public health with proof of completed immunization for diphtheria, tetanus, polio, pertussis, measles, mumps, rubella, meningococcal and varicella (chicken pox)* or with the appropriate documentation if they choose not to have their child immunized:** Statement of Medical Exemption (Form 1) or Statement of Conscience or Religious Belief Affidavit (Form 2). Please contact HPEPH for more information at 613-966-5500 ext. 221. **Please complete the following section at the time of school registration and attach a photocopy of your child's immunization record (ensure child's name and date of birth are recorded on the photocopy).** The school will forward the completed form to HPEPH, who will review the immunization information and maintain a record for each student. If your child's immunization is not complete, you will be notified by HPEPH. To avoid potential suspension, please ensure we have a complete, up-to-date immunization record for your child.

Immunization records and updates are *NOT* automatically provided to public health by your doctor.
There are three options available to update HPEPH with your child's immunization records:
Phone: 613-966-5500 ext. 221 Fax: 613-966-8145 Email: CDCIMM@hpeph.ca

***Chickenpox vaccine is required for school attendance only if born in 2010 or later. It is recommended that all children born on or after Jan 1, 2000 receive 2 doses of the vaccine, if they have not had the disease.**

STUDENT INFORMATION **(Please Print. Ensure ALL information is completed.)**	Date: _____ year / month / day
Last Name:	
First Name:	
Date of Birth: year / month / day	☐ M ☐ F
Ontario Health Card Number:	
Parent / Guardian:	
Postal Mail Address:	
City: Postal Code:	
Phone (Cell): (Home): (Other):	
School that child is or will be attending:	
Previous School: name of school city/town / province	

We are committed to providing accessible publications, programs and services to all.
For assistance please call 613-966-5500; TTY 711, or email accessibility@hpeph.on.ca.
For more information, visit www.hpepublichealth.ca.

IMM-152
2017/07/12

This information is collected under the authority of the *Health Protection and Promotion Act R.S.O 1990 c.H.7., s.4* and the *Immunization of School Pupil's Act 1990.* The personal health information collected on this form will be used to maintain immunization records and to monitor the use of vaccines for public health purposes. Questions regarding the collection and use of personal health information should be directed to the Privacy Officer, Hastings Prince Edward Public Health, 179 North Park St., Belleville, ON K8P 4P1, 613-966-5500 or 1-800-267-2803.