



**SCHOOL HEALTH SUPPORT SERVICES**

199 County Court Blvd.  
Brampton, Ont. L6W 4P3

Tel: (905) 796-0040  
Toll Free: 1-888-733-1177  
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**APPLICATION FOR SCHOOL HEALTH SUPPORT SERVICES**

**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 STUDENT'S NEEDS/PROBLEMS:** \_\_\_\_\_  **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 reports, relevant to the care and status of my child \_\_\_\_\_ (student's name) to the Community Care Access Centre of Peel (CCAC) as deemed necessary for consideration of School Health Support Services.

Student's Health Card Number: \_\_\_\_\_ Version: \_\_\_\_\_

Student (if over 16 years) or Custodial Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
Day/Month/Year

Witness: \_\_\_\_\_ Date: \_\_\_\_\_  
Day/Month/Year

**Date:** \_\_\_\_\_ Day/Month/Year **Principal's Signature:** \_\_\_\_\_

The above information is required by the CCAC of Peel in accordance with the Long-Term Care Act, 1994 to determine you or your child/youth's eligibility for CCAC services.

As a CCAC 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 CCAC's ability to provide services. No information is released for any other purpose, without your consent, unless required by law.



School Health Support Services  
**Dietetics Referral Checklist**

Student Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

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

Medical Diagnosis: \_\_\_\_\_

Reason for Referral – Student requires dietetic intervention for one or more of the following reasons:

- management of Enteral tube feeds
- management of malnutrition
- difficulty with swallowing
- management of gastrointestinal disorders
- Education re: newly diagnosed or unstable disease process

Please specify \_\_\_\_\_

other (please specify) \_\_\_\_\_

\_\_\_\_\_

Other Relevant Information:

Teacher's Name: \_\_\_\_\_

Signature: \_\_\_\_\_  
(Please Print)

Date: \_\_\_\_\_



School Health Support Services  
**Nursing Referral Checklist**

Student Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

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

Medical Diagnosis: \_\_\_\_\_

Reason for Referral – Student requires nursing intervention for one or more of the following reasons:

- 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) \_\_\_\_\_  
\_\_\_\_\_

Other Relevant Information:

Teacher's Name: \_\_\_\_\_

Signature: \_\_\_\_\_  
(Please Print)

Date: \_\_\_\_\_



## School Health Support Services Occupational Therapy School Questionnaire

This form is to be completed by the classroom teacher with input from support personnel as appropriate. The information will assist in determining the potential need for assessment and intervention by an Occupational Therapist.

Please use the following scale and circle the number that best reflects the student's ability to perform the identified task.

1. Never    2. Occasionally    3. Frequently    4. Consistently    5. Unsure

<b>Student Name:</b> _____ <b>D.O.B.:</b> _____ (Day/Month/Year)
<b>School Name:</b> _____

### B.

#### C. GENERAL CLASSROOM BEHAVIOUR

1	2	3	4	5	Is the student able to concentrate to complete work activities?
1	2	3	4	5	Is the student able to follow verbal instruction?
1	2	3	4	5	Is the student able to follow written instruction?
1	2	3	4	5	Is the student able to organize his/her workspace?
1	2	3	4	5	Is the student able to work independently?
1	2	3	4	5	Is the student able to follow classroom routines (i.e.: line-ups)?
1	2	3	4	5	Does the student ask for help/make needs known in classroom?
1	2	3	4	5	Is the student able to contribute to group discussions?
1	2	3	4	5	Does the student accept changes in routine easily?
1	2	3	4	5	Does the student demonstrate appropriate behaviour?

#### D. ORGANIZATION

1	2	3	4	5	Does the student finish activities on time?
1	2	3	4	5	Does the student demonstrate a sense of time as expected?
1	2	3	4	5	Is the student able to read without losing his/her place?
1	2	3	4	5	Is the student able to keep track of personal and school materials?
1	2	3	4	5	Is the student able to keep track of homework/notes from his/her teacher?

#### E. MANAGEMENT OF CLASSROOM TOOLS AND ACTIVITIES

1	2	3	4	5	Does the student use all work/activity centers?
1	2	3	4	5	Does the student enjoy messy media?
1	2	3	4	5	Is the student able to use all classroom materials (i.e.: rulers, scissors, crayons, pencils, eraser)?
1	2	3	4	5	Does the student demonstrate good posture for seated/floor activities?
1	2	3	4	5	Is the student able to cut scissors appropriately?
1	2	3	4	5	Does the student consistently use a dominant hand?



Student Name: \_\_\_\_\_ School: \_\_\_\_\_

### F. WRITTEN WORK

1	2	3	4	5	Does the student meet classroom expectations for volume of written work?
1	2	3	4	5	Does the student meet classroom expectations for speed of written work?
1	2	3	4	5	Does the student meet classroom expectations for legibility of written work?
1	2	3	4	5	Does the student participate in structured printing/cursive writing program?
1	2	3	4	5	If referring for cursive writing, is the student's printing functional?
1	2	3	4	5	Does the student participate in a structured keyboarding program?

### G. GYM/PLAYGROUND PERFORMANCE AND RECREATION LEISURE

1	2	3	4	5	Does the student actively play with peers at recess?
1	2	3	4	5	Is the student aware of personal safety in the gym/playground?
1	2	3	4	5	Does the student participate in recreational/extra-curricular activities?
1	2	3	4	5	Does the student play on gym and outdoor equipment (i.e.: climbing apparatus, scooter boards, etc.)?
1	2	3	4	5	Does the student acquire newly introduced gym skills alongside peers?
1	2	3	4	5	Does the student demonstrate well coordinated movement patterns (i.e.: action songs, rhythmical movement to music, etc.)?
1	2	3	4	5	Does the student demonstrate fair endurance for active gym/playground play?

### H. ACADEMIC PERFORMANCE

1	2	3	4	5	Does the student have primary concepts (pre-reading, pre-writing)?
1	2	3	4	5	Is the student's reading ability age appropriate?
1	2	3	4	5	Is the student's spelling ability age appropriate?
1	2	3	4	5	Is the student's journal work/written work age appropriate?
1	2	3	4	5	Is the student's computer skills age appropriate?

### I. MANAGEMENT OF ACTIVITIES OF DAILY LIVING

1	2	3	4	5	Does the student demonstrate skills for independent hygiene?
1	2	3	4	5	Is the student able to manage outdoor clothing?
1	2	3	4	5	Is the student able to manage clothing fasteners (zippers, buttons, laces, etc.)?
1	2	3	4	5	Is the student able to manage gym clothing?
1	2	3	4	5	Is the student independent in toileting?
1	2	3	4	5	Is the student independent at school meal times (i.e.: lunch, snack)?



Student Name: \_\_\_\_\_ School: \_\_\_\_\_

**J. SOCIAL SKILLS**

AGREE	DISAGREE	UNSURE	
			Does the student have a close friend?
			Does the student play with same age peers?
			Is the student liked by other children?
			Does the student demonstrate positive self-esteem?
			Does the student play cooperatively and appropriately with others?
			Is the student able to resolve conflicts appropriately?

**Is the student motivated to participate in therapy sessions? Please comment.**

**Please list 3 primary areas of concern you have about the student in your classroom. If written work is of concern, please provide a sample.**

- 1.
- 2.
- 3.

**Teacher's Comments: (Please identify key strengths of the student in your classroom.)**

Teacher's Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
(Please Print)

Date: \_\_\_\_\_



School Health Support Services  
**Physiotherapy Referral Checklist**

Student Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

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

Medical Diagnosis: \_\_\_\_\_

Reason for Referral – Student demonstrates impairment in one or more of the following areas:

- safety issues with mobility
- safety issues with transfers
- equipment issues related to mobility
- frequent falls
- gross motor
- balance/postural control
- joint mobility (decreased range of motion)
- strength
- endurance/activity tolerance
- cardio respiratory condition
- pain management
- movement disorders/coordination
- mobilization post surgical procedure
- neurological deficits
- assessment for lower extremity bracing or orthotics

Other Relevant Information:

Teacher's Name: \_\_\_\_\_

Signature: \_\_\_\_\_  
(Please Print)

Date: \_\_\_\_\_





Student Name: \_\_\_\_\_ School: \_\_\_\_\_

**SECTION 2 – Cont'd.**

- phonology or articulation delay/disorder of the following severity :  Moderate  Severe/Profound  
Student demonstrates one or more of the following:

- 3 sounds or more in error (excluding age appropriate errors or errors that are appropriate considering the client's language age)

Sound  
Position(s) (circle)

- an oral-motor component with a significant effect on speech-production/intelligibility resulting in less than 80% intelligibility of connected speech as judged by the referring clinician and due primarily to one or more of the following functional motor speech indicators (check all that apply).

**Respiratory**

- breath support is inadequate  monoloudness  
 short phrases due to reduced breath support

**Laryngeal**

- breathiness  monopitch  
 harsh vocal quality

**Palatal**

- over-riding hypernasality  over-riding hyponasality  
 hypernasality accompanied by nasal air emission

**Facial, Lingual, Labial**

- hypotonic facial tone  
 hypertonic facial tone  
 jaw movement shows poor range, stability and/or control  
(specify): \_\_\_\_\_  
 lip structure and function shows reduced strength, speed, range or coordination  
(specify): \_\_\_\_\_  
 tongue structure and function shows reduced strength, speed, range or coordination  
(specify): \_\_\_\_\_

**Distinctive Speech Production Characteristics**

- |   |  |
|---|--|
| <input type="checkbox"/> slow rate due to oral motor weakness or respiratory problems | <input type="checkbox"/> effortful groping for correct articulatory postures, at times with facial grimacing |
| <input type="checkbox"/> imprecise consonant production                               | <input type="checkbox"/> perseverative, anticipatory and/or transposition errors                             |
| <input type="checkbox"/> distorted vowel production                                   | <input type="checkbox"/> voicing/voiceless errors  |
| <input type="checkbox"/> fairly consistent articulation errors                        | <input type="checkbox"/> difficulty initiating speech  |
| <input type="checkbox"/> highly inconsistent articulatory errors                      | <input type="checkbox"/> increased errors as phonemic sequence increases                                     |

- fluency disorder:  Mild  Moderate  Severe/Profound  
Describe: \_\_\_\_\_

- Other:  
 referral initiated at parent request: Parents have been informed that the child may not meet the referral criteria for this program  
 referral initiated at school request: School has been informed that the child may not meet the referral criteria for this program  
 reason for referral \_\_\_\_\_

Thank you for referring this student to the CCAC of Peel. A case manager will contact the school and parents to confirm if the child is eligible to receive CCAC services.