

JORDAN'S PRINCIPLE CAREGIVER CONSENT FORM

Jordan's Principle is an initiative that our community has implemented to help support First Nations children overcome barriers to support and care they require to maintain a safe and healthy lifestyle. We ask caregivers to provide their written consent before we proceed to develop a collaborative case plan to support their child/children.

Child's Name:		Child's Birthdate:	___/___/___ mm / dd / yyyy	Child's Gender:	__ male __ female __ other
Caregiver 1 Name:			Caregiver 2 Name:		
Caregiver 1 Contact:	Address:		Caregiver 2 Contact:	Address:	
	Phone:			Phone:	
Professional Requesting Consent:	Name: Sheila Buck RNBN Jordan's Principle Case Coordinator		Contact of Professional Requesting Consent:	Email: sheila.buck@ocnhealth.com	
	Organization: Opaskwayak Health Authority			Phone: 204-627-7298	
Section 1: PURPOSE OF CONSENT	I consent to the sharing of my/my child's personal information and/or personal health information between the organizations/agencies listed below in section 3. The purpose of sharing information about me/my child is to allow the service providers from each agency to discuss my/my child's situation and develop a complete service plan that will address my/my child's health and well-being needs.				
Section 2: CONFIDENTIALITY	I understand that the information shared will be on a need to know basis only. It is also my understanding that each of the participating organizations/agencies listed in Section 3 will maintain confidentiality of the information in accordance with standard organizations/agency and government policies, legislation such as <i>The Freedom of Information and Protection of Privacy Act (FIPPA)</i> , <i>The Personal Health Information Act (PHIA)</i> and Regulations, <i>Federal Privacy Act</i> , the <i>Access to Information Act</i> and any other applicable legislation.				
Section 3: PERMISSION	<p>Please select which organizations that you give permission to be part of the case conference:</p> <p><input checked="" type="checkbox"/> Jordan's Principle Services Coordinator</p> <p>___ Child's School: _____ (print)</p> <p>___ Child's Day Care: _____ (print)</p> <p>___ Child's Family Doctor: _____ (print)</p> <p>___ Child Family Services: _____ (print)</p> <p>___ Family Enhancement: _____ (print)</p> <p><input checked="" type="checkbox"/> Indigenous Services Canada _____ (print)</p> <p>___ Other: _____ (print)</p> <p>___ _____ (print)</p>				
Caregiver 1 Signature:	Type text here		Date:		
Caregiver 2 Signature:			Date:		

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