2023

Intake for Treatment Package

Nimkee Nupigawagan

Healing Centre

NIMKEE NUPIGAWAGAN HEALING CENTRE

GENERAL INFORMATION

CLIENT NAME:	DATE OF BIRTH: AGE:
CLIENT FIRST NATION:	
If by referral, who is making the referral?	Name: Agency Name: Role: Phone: Email: Fax:
How many sessions have you had with the client?	Number of sessions:
Will you continue to support your client through and after their stay at the Treatment Facility? YES ☐ NO ☐	
PHOTOGRAPH OF CLIENT (can be taken later upon entry)	

CLIENT INFORMATION

Legal name: _____ Spirit Name: _____

Nation: _____

Social Insurance Number: _____ Health Card Number: _____

Street Address: _____ City: _____

Province: _____ Postal Code: _____

Telephone: _____ Email Address: _____

Status Card Copy (Front and Back)

NIMKEE NUPIGAWAGAN HEALING CENTRE

FAMILY HISTORY

List all people currently living in your household(s) and their relationship to the youth. (If youth lives in two homes, list both and specify the amount of time in each home).

List others who are not living in the home but who are actively involved with your child:

Parent(s) current relationship status:

Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Widowed ☐ Other ☐

If Other, please specify: _____

What is your custody agreement?

Joint Legal ◯ Joint Physical ◯ Sole Legal ◯ Sole Physical ◯ Other _____

Child's age at time of separation? _____ Child's age at time of divorce? _____

If divorced or separated, are both parents consenting to this evaluation/treatment? Yes ☐ No ☐

If no, please explain:

Are there any concerns or events that have occurred within the family that may be important to know about when working with your child?

What has been helpful and/or not helpful to your family in dealing with these concerns?

Have there been any community resources that have been useful to your family?

Additional information:

YOUR CHILD'S SOCIAL HISTORY

Has your child experienced any major losses and/or separations? Yes ☐ No ☐

If yes, please provide details:

In the past, has your child had difficulties separating from familiar people? Yes ☐ No ☐

Is this still a problem? Yes ☐ No ☐

If yes to either, please describe:

Does your child seek out friends?	YES ☐ NO ☐
Do peers seek out your child?	YES ☐ NO ☐
Does your child play primarily with children their own age?	YES ☐ NO ☐
Does your child fight frequently with peers?	YES ☐ NO ☐
Do you have any concerns about your child's friendships? If no, please explain:	YES ☐ NO ☐

What are three strengths that best describe your yourself?

How do you spend your free time?

What activities do you enjoy doing the most?

For parents of pre-teens, does your child have a curfew? YES ☐ NO ☐

Does your child adhere to curfew? YES ☐ NO ☐

Does your child date? YES ☐ NO ☐

What is your teen's exposure and/or attitude toward drugs, nicotine, alcohol?

Is it of concern to you?

NIMKEE NUPIGAWAGAN HEALING CENTRE

CLIENT INFORMATION - CONTINUED

Client name: _____ **Date**: _____

Should I leave Nimkee Nupigawagan prior to program completion, I agree to utilize the support of Nimkee Nupigawagan staff for resource information, and safe exit/transition planning and:

- Return to my home and/or the home of the individual named below for immediate shelter and transition support;and/or
- Contact the agency/worker named below for immediate shelter and transition support.

EMERGENCY CONTACTS (list by priority):

Name	Relationship	Phone	Email Address

Client Family Information

Do you have any children under 19?	**YES** ☐ **NO** ☐
Are they living with you?	**YES** ☐ **NO** ☐
Is Child Welfare involved with your family?	**YES** ☐ **NO** ☐
Please provide additional info, if necessary:	

CHILD WELFARE INVOLVEMENT OF PARTICIPANT (Under Age 21)

Crown Ward	
Indigenous Child Welfare Agency	
Details: (Worker, agency name, background)	

NIMKEE NUPIGAWAGAN HEALING CENTRE

CULTURAL INFORMATION

We invite you to let us know if there are any traditional practices or ceremonies that will support your wellness while at Nimkee:

Is there anything you would like us to know that we have not included here about you or your culture practices/ community?

Do you identify yourself as an Indigenous person, that is First Nations or Inuit?	First Nations ☐	Inuit ☐
Status:	Yes ☐	No ☐
Band:		

Have you participated in any traditional indigenous ceremonies prior to treatment (please check)			
Traditional Healer	☐	Fasting/Fasting Camp	☐
Sundance	☐	Healing Circles	☐
Full Moon Ceremony	☐	Sacred Fire	☐
Sweatlodge	☐	Helper	☐
Other:	☐	Other:	☐
What types of indigenous crafts have you tried or want to try (please check):			
Beading	☐	Dreamcatchers	☐
Medicine Bundles	☐	Sewing	☐
Ribbon Skirt/Shirt	☐	Art	☐
Regalia	☐	Carving	☐

WE will have each person fill out this questionnaire on strengths, interests and hopes because we hope that people can actively reflect. We will also enlist the help of other friends and family to assist us- we will provide forms to each person that the applicant identifies. It will be 1) family member, 1) friend and 1) sibling (if available).

CLIENT'S STRENGTHS, INTERESTS, HOPES

Tell us about your strengths and positive qualities- Look within yourself or think about what others have complimented you on- everyone is good at something, everyone has gifts. Tell us about your gifts and your positive attributes.

Tell us about your interests, talents and passions. What do you like to do? What have you done in the past that has brought you excitement and good feelings in mind, body, and heart?

Tell us about your hopes for treatment- Why do you want to attend treatment? (Try to write at least a few paragraphs so that we can look at your reasons)

NIMKEE NUPIGAWAGAN HEALING CENTRE

SUBSTANCE USE TREATMENT HISTORY

CLIENT NAME: _____ DATE: _____

1. Have you completed a withdrawal management program (including home detox, daytox) in past? YES ☐ NO ☐

   If yes, please list most recent dates, where, and for what substances:

2. Have you ever participated in substance use services and supports? YES ☐ NO ☐
   (including counsellor, NNADAP, outpatientclinic, AA, NA, etc.)

   If yes, please list most recent dates, where, and what substances you were using at the time

3. What has been helpful in your past recovery or support experiences, including First Nation/Indigenous Support Services?

4. What has been unhelpful in your past treatment or support experiences, including First Nation/Indigenous SupportServices?

NIMKEE NUPIGAWAGAN HEALING CENTRE

GENDER AND SEXUAL ORIENTATION

Nimkee is a gender-separated service. Respectful of gender diversity, we will work with clients to figure out how to provide services in this setting which will be mutually respectful according to applicants self- identified gender and sexual orientation. Gender is diverse and we invite you to let us know what gender you identify with:

Male ☐	Female ☐	Gender Creative/Fluid ☐	Transgender MTF ☐
Transgender FTM ☐	Other ☐	Prefer not to answer ☐	☐

What pronoun would you like us to use? He ☐ She ☐ They ☐

Sexual orientation is diverse, and we invite you to let us know your sexual orientation:

Heterosexual ☐	Lesbian ☐	Gay ☐	Bisexual ☐
Queer ☐	Questioning ☐	Two-Spirit ☐	Pansexual ☐
Asexual ☐	Other ☐	Prefer not to answer ☐	

Is your reason for getting help (substance use, mental health concerns) related to any issues around your sexual orientation or gender identity?

Not at all ◯ A little ◯ Somewhat ◯ A lot ◯ Unsure ◯ Prefer not to answer ◯

SUBSTANCE MISUSE

Primary Problem Rate 1-5 1-Low 5-Major	Substance	Primary Route Of use Oral, nasal, Sublingual, Smoke, inhale, anal, intravenous, intra.muscular, transbuccal	# of Days Used in last 30 days	Typical Daily Usage	Age at first use	Current Use	Stage of Change Event
	Alcohol						
	Tobacco						
	Cannabis						
	Crack Cocaine						
	Cocaine						
	Heroin						
	Opiates						
	Solvents						
	Crystal Meth						
	Amphetamines						
	Club Drugs						
	Hallucinogens						
	Inhalants						
	Over the Counter						
	Other Rx Meds						
	Methadone						

Have you ever accidentally overdosed? YES ☐ NO ☐

If yes, please tell us briefly about the most recent date this happened:

Have you ever experienced alcohol-poisoning, including black-outs /pass-outs? YES ☐ NO ☐

Tell us about this experience (when/where/outcome)

OTHER PROBLEMATIC BEHAVIOURS

Do you or anyone in your life have concerns that you might have problems with any of the following behaviours (that is,you spend a lot of time, spend more money than you intended and/or it's interfering with other responsibilities)?

Activity	YES	NO	HOURS PER DAY/MONTH
Shopping	☐	☐	
Sexual activity	☐	☐	
Gambling	☐	☐	
Gaming	☐	☐	
Other (Internet Overuse, Shoplifting, Theft)	☐	☐	
Other	☐		

NIMKEE NUPIGAWAGAN HEALING CENTRE

CLIENT'S HEALTH

CLIENT NAME: _____ DATE: _____

Immunizations – (Attach all, including immunization for Covid-19 below)

Are you pregnant?	YES	☐	NO	☐	UNSURE	☐	Number of weeks pregnant:	
Do you have a history of seizures?	YES	☐	NO	☐	Date of last seizure			

If yes, please let us know the cause of the seizures, if known (substance use related?):

Do you have any of the following ongoing health conditions? (please check)

Asthma	☐	Breathing problems	☐	Heart problems	☐	Circulatory issues	☐	Stomach problems	☐	Anxiety	☐

Do you take medication for these conditions? If so, describe below:

Do you have diabetes? YES ☐ NO ☐ Is it managed with medication? YES ☐ NO ☐

Do you have allergies? YES ☐ NO ☐ What is required to manage them?

Do you require an epi-pen for allergies? YES ☐ NO ☐

Do you have any special dietary needs? YES ☐ NO ☐

If yes, please describe:

Do you have mobility issues? YES ☐ NO ☐

If yes, please tell us briefly about your mobility concerns/needs:

CLIENT MENTAL HEALTH

Do you have any mental health concerns? YES ☐ NO ☐

What are your concerns?

Have you received a mental health diagnosis? YES ☐ NO ☐

If yes, please elaborate:

Are you on medication(s) for your mental health concerns? YES ☐ NO ☐

If yes, what medication are you taking? _____

Is this medication helpful? YES ☐ NO ☐

Please comment:

CLIENT MENTAL HEALTH CONTINUED

When was the last time you had significant problems with:

1. Feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?									
Past month	◯	2-3 mos. ago	◯	4-12 mos. ago	◯	Over a year ago	◯	Never	◯
2. Sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?									
Past month	◯	2-3 mos. ago	◯	4-12 mos. ago	◯	Over a year ago	◯	Never	◯
3. Feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?									
Past month	◯	2-3 mos. ago	◯	4-12 mos. ago	◯	Over a year ago	◯	Never	◯
4. Becoming very distressed and upset when something reminded you of the past?									
Past month	◯	2-3 mos. ago	◯	4-12 mos. ago	◯	Over a year ago	◯	Never	◯
5. Seeing or hearing things that no one else could see or hear, or feeling that someone else could read or control your thoughts?									
Past month	◯	2-3 mos. ago	◯	4-12 mos. ago	◯	Over a year ago	◯	Never	◯

Do you have a history of disordered eating? YES ☐ NO ☐

If yes, please elaborate:

Binging ◯ Purging ◯ Restricting ◯ Laxatives ◯ Excessive Exercising ◯ Other ◯

Have you ever participated in treatment for disordered eating? YES ☐ NO ☐

If yes, please tell us briefly about this:

Is the disordered eating still active? YES ☐ NO ☐ If no, when was it last active? _____

Do you engage in self-harming behaviours (cutting, burning, scratching)? YES ☐ NO ☐

If yes, is self-harm currently active? YES ☐ NO ☐

Please comment:

CLIENT MENTAL HEALTH CONTINUED

Do you have thoughts of suicide? YES ☐ NO ☐ NOT ASSESSED ☐

If yes, do you have a current plan for suicide? YES ☐ NO ☐

If yes, please elaborate:

Have you ever attempted suicide? YES ☐ NO ☐

If yes, date of most recent attempt: _____

Have you experienced a head injury or head trauma? YES ☐ NO ☐

Please explain current head injuryrelated concerns:

Do you often feel confused or overwhelmed in new places? YES ☐ NO ☐

If yes, please tell us more information about this:

CURRENT MEDICATIONS

Note: We will need verification from a medical practitioner. A consent form is attached (see Physical Form that is required)

Do you have any concerns about your current medication(s)? YES ☐ NO ☐

Are you on opiate maintenance therapy? YES ☐ NO ☐

If yes, which therapy? _____ Who is your care provider? _____

Start date: _____ Current dose: _____

Current opiate maintenance therapy details:

PSYCHOLOGICAL AND SOCIAL

Have you ever experienced problems controlling your anger / aggression? YES ☐ NO ☐

If yes, please tell us briefly about any anger or aggression concerns that are current or in the recent past:

Are you currently experiencing violence? YES ☐ NO ☐
(including domestic violence or intimate partner violence)

Have you experienced violence in the past? YES ☐ NO ☐

If yes, please tell us briefly about any concerns related to your current safety:

Do you have concerns for your safety related to your care in this program? YES ☐ NO ☐

If yes, please elaborate:

Do you have safety concerns related to aftercare? YES ☐ NO ☐

If yes, please elaborate:

Do you have any concerns about being in a group setting/environment? YES ☐ NO ☐

If yes, please elaborate:

HOUSING

What is your current housing situation?

Is your current housing situation safe, or unsafe? Please describe:

Do you need help with a housing plan? YES ☐ NO ☐

Who do you live with? What's your family circumstances? Please describe:

LEGAL CIRCUMSTANCES

Do you have any upcoming court dates? YES ☐ NO ☐

If yes, when and where? Please attach more information if needed:

Are you court-ordered or asked by an alternative court system to attend treatment? YES ☐ NO ☐

Are you on probation or parole? YES ☐ NO ☐

Do you have a conditional sentence? YES ☐ NO ☐

Do you have any charges? YES ☐ NO ☐

If yes to any of the above, please provide contact information on consent form.

NIMKEE NUPIGAWAGAN HEALING CENTRE

FINANCIAL CIRCUMSTANCES

What is your income source during your time at Nimkee? INCOME ASSISTANCE ◯ NONE ◯ OTHER ◯

Have you applied for Income Assistance? YES ☐ NO ☐ I DON'T KNOW ☐

If yes, what is the application number? _____

Do you require assistance with income applications/jobs after completion? YES ☐ NO ☐

EDUCATIONAL HISTORY

Highest education completed:	Please check
High School	☐
College	☐
University	☐
Trade	☐
Certificate	☐

Please attach last final school record, so that we can adequately assess your needs including any reports orassessments if available.

Do you want help with an educational plan upon completion of program? YES ☐ NO ☐
(We will review this again during the program)

TRANSPORTATION ARRANGEMENTS

Travel arrival/return by:

Mode (please check)		Date	Who will arrange?		Date
Car	☐		**Parent**	☐	
Bus	☐		**Band**	☐	
Air	☐		**Counsellor**	☐	
Other	☐				

***Note- it is not Nimkee NupiGawagan's expense for travel, except in some emergency situations, as deemed by the Executive Director or Director of Care. We will help to obtain costs for transportation if needed.**

WORKER ATTESTATION

I have reviewed all the application and filled out with the participant on the following dates:

Date: _____ Date: _____ Date: _____	**Comments**:	**Initials:** _____

PRIVACY AND CONSENT

Privacy at Nimkee NupiGawagan

- When you are receiving care from any of the programs or services at Nimkee Nupigawagan Healing Centre (NNHC), personal information needs to be collected from you by counsellors, health care practitioners and other healthcare team members.
- We collect, use and share this information when required or permitted by law; for example, according to the Personal Health Information and Protection Act (PHIPA).
- Sometimes your family, friends, or someone who has the legal right to represent you, may also give us personal information about you.
- We may also need to get personal information from other sources, such as copies of your previous health records from other hospitals or from your family physician, or we may confirm your identity and Ontario Health Card) with the Ministry of Health.

Nimkee NupiGawagan is ethically committed and legally required, to protect your personal information.

We are committed and legally required by *Personal Health and Information and Protection Act (PHIPA)* to protect your privacy. We use and share your information for authorized purposes and must store it securely to protect it. Our staff are trained on how to protect your privacy and to keep your personal information confidential at all times.

Who can look at, use, and share my personal information?

Someone who "**needs to know**" your information in order to provide care and other care-related services, is permitted to look at your personal information (like a counsellor or a nurse). They may use and share it for the following reasons:

- To assist with your ongoing care and services
- To contact you or your family about your medical care when appropriate
- To help us improve the quality of your care and services
- Research (when authorized)
- Teaching and education (of counsellors and nurses, for example)
- To see if you qualify for different benefits or services and to arrange payment.

Your personal information may also be shared with other people with your consent. However, we must provide it without your consent in some circumstances. These include:

- To respond to a court order or subpoena
- To comply with an insurance investigation by another government body eg. insurance
- To report or provide information to investigate a suspicion that a child or an older adult is being abused or neglected
- To report intention of self-harm or harm to another person

If you have any questions or concerns about the limits of confidentiality, you are encouraged to speak with your counsellor, health care provider, or the Executive Director. Our program is committed to being as open as possible about our responsibilities to both you and the community

NIMKEE NUPIGAWAGAN HEALING CENTRE

CONSENT FOR THE RELEASE OF INFORMATION

Please indicate below your consent for Nimkee NupiGawagan staff to share your personal information with thefollowing individuals:

SERVICE PROVIDER	NAME	Telephone (include extensions)	Specify any limitations to the information you consent to share
Probation or Parole Officer			
Lawyer			
Parent			
Other			

CLIENT AUTHORIZATION

I, _____ (full name) have reviewed the information in the Privacy and Consent section (page 19). I consent to the release of information as specified above (if applicable)

_____ _____

PRINTED NAME SIGNATURE

_____

DATE

If under the age of 16, parent or guardian signature required:

_____ _____

PARENT/GUARDIAN PRINTED NAME PARENT/GUARDIAN SIGNATURE

_____

DATE

_____ _____

WITNESS PRINTED NAME WITNESS SIGNATURE

_____ _____

DATE RELATIONSHIP

NNHC collects, uses, and shares personal information only in accordance with the Personal Health Information and Protection Act (PHIPA)

NIMKEE NUPIGAWAGAN HEALING CENTRE

PARTICIPANT AGREEMENT

I, _____ (full name) have reviewed the referral information and Client Considerations section. I agree to voluntarily apply for services with Nimkee NupiGawagan.

I agree while I am in the program I will:

- treat others with respect and dignity and without discrimination
- honour the privacy and right to confidentiality of others
- participate fully in programming and opportunities

I agree to participate in the following activities upon arrival at Nimkee NupiGawagan or produce this in advance:

- medical assessment with the program doctors and nurses
- medication review including handing in all medications to the program staff
- drug testing, if requested
- review of your personal belongings in your presence
- program orientation with staff
- Rapid Antigen Testing/Covid testing, if required

_____ _____

PRINTED NAME SIGNATURE

_____

DATE

_____ _____

PARENT/GUARDIAN PRINTED NAME PARENT/GUARDIAN SIGNATURE

_____

DATE

COMMUNITY COUNSELLOR/HEALTH CARE PROFESSIONAL

_____ _____

PRINTED NAME SIGNATURE

_____

DATE

QUESTIONS

Nimkee NupiGawagan Healing Centre

Email: admissions@nimkee.org

519 870-1119 Leroy Cornell

1-888-685-9862

Hours of Operation: 8:00am-4:00pm, Monday to Friday- Closed during lunch12-1 pm

NIMKEE NUPIGAWAGAN HEALING CENTRE

AGREEMENT FOR YOUTH TREATMENT SERVICE

YOUTH NAME: _____ **DATE OF BIRTH**: _____

I/We understand, agree and consent that Nimkee NupiGawagan Healing Centre will provide for the care of the *above-named youth* for the duration of time that she / he is in residential treatment with NNHC.

I/We understand, agree and consent that Nimkee NupiGawagan Healing Centre will, if necessary, obtain emergency medical treatment for the *above-named youth*.

I/We understand, agree and consent that Nimkee NupiGawagan Healing Centre will wherever applicable inspect and obtain from persons named in the authorization to release/access information, records, reports and informationconcerning the *above-named youth*.

I/We understand and agree that this signed service agreement further validates the following forms and consents that were signed on behalf of the *above-named youth* as a requirement for acceptance into the NNHC residential treatment program:

- Parent / Guardian Consent Form
- Consent to Medical Treatment
- Authorization to Access/ Release Information
- Liability Waiver
- Referral Agent Agreement
- AWOL Procedures Form
- Education Consent
- Terms of Agreement to Policy between Client & Healing Centre
- Medical Assessment

Nimkee NupiGawagan will provide opportunity for review of this agreement at any point during the duration of youth treatment service upon the request of the parent/guardian, agency referral worker or the youth in treatment.

I have been explained the details of this service agreement YES ☐ NO ☐

_____ _____
SIGNATURE OF CLIENT DATE

_____ _____
PRINTED NAME OF PARENT/GUARDIAN SIGNATURE OF PARENT/GUARDIAN

_____ _____
PRINTED NAME OF WITNESS (PARENT/GUARDIAN) SIGNATURE OF WITNESS (PARENT/GUARDIAN)

_____ _____
PRINTED NAME OF NNHC PERSONNEL SIGNATURE OF NNHC PERSONNEL

_____ _____
PRINTED NAME OF NNHC WITNESS SIGNATURE OF NNHC WITNESS

_____
DATE

NIMKEE NUPIGAWAGAN HEALING CENTRE

AGREEMENT FOR SERVICE – FINANCIAL ARRANGEMENTS

YOUTH NAME: _____ DATE OF BIRTH: _____

I/We understand and agree that that the accommodation, treatment, and all services involved for the success of the treatment of the *above-named youth* are free of cost for those responsible for the youth (parent/guardians).

Services such as accommodation (room and general supplies for the comfortable stay of the youth), cleaning, meals, treatments, cultural, sports, and recreational activities are free of charge, once they are part of the youth treatment program.

Supplies related to their daily routine at the Nimkee NupiGawagan Healing Centre such as bedroom, kitchen, common area, personal hygiene, alimentation, sports, recreation, arts and craft are provided for free, with any cost for the parents/guardians as they are considered part of the youth treatment work plan.

Acknowledgement:

_____ _____
SIGNATURE OF CLIENT DATE

_____ _____
PRINTED NAME OF PARENT/GUARDIAN SIGNATURE OF PARENT/GUARDIAN

_____ _____
PRINTED NAME OF WITNESS (PARENT/GUARDIAN) SIGNATURE OF WITNESS (PARENT/GUARDIAN)

_____ _____
PRINTED NAME OF NNHC PERSONNEL SIGNATURE OF NNHC PERSONNEL

_____ _____
PRINTED NAME OF NNHC WITNESS SIGNATURE OF NNHC WITNESS

_____
DATE

NIMKEE NUPIGAWAGAN HEALING CENTRE

AGREEMENT FOR SERVICE – INSPECT/OBTAINED RECORDS/REPORTS

YOUTH NAME: _____ DATE:_____

I/We authorize that the youth's case record can be reviewed for the license, if applicable, and inspect records, reports, and information concerning the above-named youth.

Acknowledgement:

_____ _____
SIGNATURE OF CLIENT DATE

_____ _____
PRINTED NAME OF PARENT/GUARDIAN SIGNATURE OF PARENT/GUARDIAN

_____ _____
PRINTED NAME OF WITNESS (PARENT/GUARDIAN) SIGNATURE OF WITNESS (PARENT/GUARDIAN)

_____ _____
PRINTED NAME OF NNHC PERSONNEL SIGNATURE OF NNHC PERSONNEL

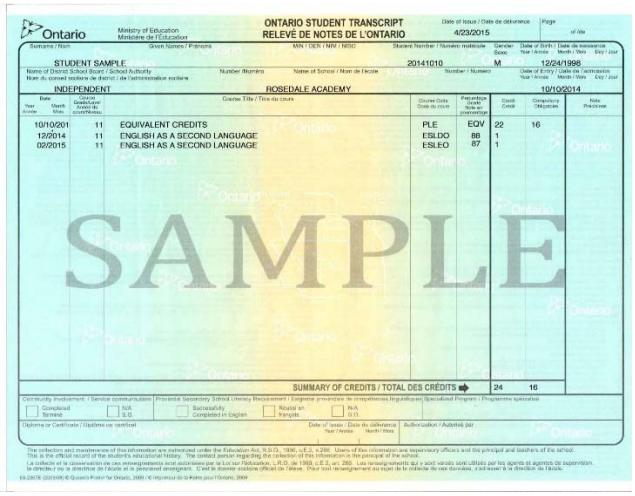
_____ _____
PRINTED NAME OF NNHC WITNESS SIGNATURE OF NNHC WITNESS

_____
DATE

NIMKEE NUPIGAWAGAN HEALING CENTRE

REQUEST FOR EDUCATION RECORDS

In order to better understand the education needs of our participants we are asking that a signed consent form along with an official school transcript (on green paper as seen in the photo below) are included with your intake package. Your last school attended can provide you with a copy of your transcript upon request. This will give us an opportunity to prepare an individualized educationprogram for participants.


Ontario

Ministry of Education
Ministère de l'Éducation

ONTARIO STUDENT TRANSCRIPT
RELEVÉ DE NOTES DE L'ONTARIO

Date of Issue / Date de délivrance: 4/23/2015

Page: of / de

Surname / Nom	Given Names / Prénoms	MIN / OEN / NIM / NISO	Student Number / Numéro matricule	Gender Sexe	Date of Birth / Date de naissance Year / Année Month / Mois Day / Jour
STUDENT SAMPLE			20141010	M	12/24/1998

Name of District School Board / School Authority Nom du conseil scolaire de district / de l'administrative scolaire	Number (Numéro)	Name of School / Nom de l'école	Number / Numéro	Date of Entry / Date de l'admission Year / Année Month / Mois Day / Jour
INDEPENDENT		ROSEDALE ACADEMY		10/10/2014

Date Year / Année	Month / Mois	Course Grade / Année du cours/Niveau	Course Title / Titre du cours	Course Code / Code du cours	Percentage Mark / Note en pourcentage	Credit / Crédit	Compulsory / Obligatoire	Note / Précisions
10/10/201		11	EQUIVALENT CREDITS	PLE	EQV	22	16	
12/2014		11	ENGLISH AS A SECOND LANGUAGE	ESLDO	88	1		
02/2015		11	ENGLISH AS A SECOND LANGUAGE	ESLEO	87	1		

SAMPLE

SUMMARY OF CREDITS / TOTAL DES CRÉDITS ➡ 24 16

Community Involvement / Service communautaire | Provincial Secondary School Literacy Requirement / Exigence provinciale de compétences linguistiques | Specialized Program / Programme spécialisé

☐ Completed / Terminé ☐ N/A S.O. ☐ Successfully Completed in English / Réussi en français ☐ N/A S.O.

Diploma or Certificate / Diplôme ou certificat | Date of Issue / Date de délivrance Year / Année Month / Mois | Authorization / Autorisé par

The collection and maintenance of this information are authorized under the Education Act, R.S.O., 1990, c.E.2, s.266. Users of this information are supervisory officers and the principal and teachers of the school. This is the official record of the student's educational history. The contact person regarding the collection of this information is the principal of the school.
La collecte et la conservation de ces renseignements sont autorisées par la Loi sur l'éducation, L.R.O. de 1990, c.E.2, art. 266. Les renseignements qui y sont versés sont utilisés par les agents et agentes de supervision, le directeur ou la directrice de l'école et le personnel enseignant. C'est le dossier scolaire officiel de l'élève. Pour tout renseignement au sujet de la collecte de ces données, s'adresser à la direction de l'école.

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We also ask that you provide us with some areas of interest in order to look intocourses and programs available for you while you are at Nimkee.

Subjects of Interest (Things you enjoy learning about):

Nimkee Nupigawagan
HealingCentre

519-264-2277

NIMKEE NUPIGAWAGAN HEALING CENTRE

LAND BASED ACTIVITIES FOR 12–17-YEAR-OLDS- JULY 2022- DECEMBER 2022
NIMKEE NUPIGAWAGAN INFORMED CONSENT

All Nimkee Nupigawagan employees are certified in Standard First Aid and CPR C and training related to providing programs and services for youth. There is an exhaustive list of mandatory training that employees complete, and each employee has vulnerable sector checks. In addition, all employees havebeen trained in new protocols, policies and standards related to COVID-19 based on provincial legislation. Our employees are carefully selected based on their past experiences, skills, enthusiasm and ability to work with indigenous youth. They also participate in a mandatory, pre-camp training program covering topics such as leadership, motivation, teamwork, parent feedback, policies and procedures, as well as specifics about programs and management expectations. There will be trained lifeguards within our program.

The purpose of this letter is to outline and secure your informed consent for your child to participate inSouthridge School's Summer Camp program. We request your immediate attention to this letter, as the program cannot commence until each consent form is returned.

The off-site camp and outdoor trips introduce students to a variety of environments and conditions. This opportunity will give participants an experience in swimming at pools, in lakes; canoeing, hiking, cooking, and cycling expeditions, for example.

The safety of our participants is the first priority in planning any outdoor activity. In addition, we ensure that the challenges presented by the excursion match the skill level of the student. However, aswith any outdoor activity, there are some inherent risks that each parent or guardian should be aware of, including but not limited to the following:

- our trips can take us "off the beaten path" with no immediate access to emergency response.
- the weather can be unpredictable, at times, and severe;
- the bays and lakes are often cold;
- students must sometimes rely upon and trust their lives to technical equipment such as certifiedropes & safety gear, life jackets, etc.
- wild animals may be present in some of the areas in which we travel.

As a consequence of Nimkee Nupigawagan land-based program, each parent, guardian and participantmust understand that participation in an off-site camp may result in an elevated risk of injury when compared to participation in a passive activity. The nature of the trip may prevent the participants from being under the direct supervision of leaders at all times.

If you are satisfied that you fully understand the nature of Nimkee Nupigawagan's Land Based Program and the off-site camps, please complete the attached consent form and submit with your registration package and email to continouscare@nimkee.org. If you have any questions or concerns, please contact Leroy or Dave at Nimkee Nupigawagan Healing Centre.

NIMKEE NUPIGAWAGAN

I understand that outdoor activities may present to my child a wide variety of risks, hazards and conditions, not all of them easily foreseeable, which could result in loss, damage or injury to my child. These conditions may include, but are not limited to, steep and uneven terrain, changeable weather conditions, including heat, cold and wetness, remoteness from normal medical services, evacuation difficulties, darkness, animal and plant life, the use of assorted vehicles and including various types of transportation like canoes, boats, equipment use and camping and cooking activities. I understand thatthe nature of some of the activities may mean an increase in incidents.

I understand it is my responsibility to determine, taking into consideration the risks, my child's behavioural characteristics, physical health and abilities, whether my child should be allowed toparticipate in the Land Based Program, which is essential part of the program.

I understand that my child will be expected to uphold the standards of behaviour expected of all participants in any land-based program, and that my child will be expected to listen to and honour any request, suggestion, advice or rule given by program staff, and other supervising adults on the activity and including without limitation, the request that my child no longer participate in the activity, with theunderstanding that this is in the best interests of all participants. My child will be expected to act with responsibility and care for themselves and for others on the activity. My child is expected not to leave any land-based programming without consent and informing program staff. If there is a breach of any of these rules and standards, Nimkee Nupigawagan may require my child to withdraw from the remainder of the program.

My child has no physical impediments that will affect their participation in hiking, walking, canoeing,swimming, and other outdoor cultural experiences and games and field trips.

I give permission for program staff to administer first aid treatment to my child and acknowledge that Iwill be responsible for any medical or other charges in connection with my child's treatment.

I understand that I have been made fully aware of the various risks involved with each land-based activity and that, upon my child's participation therein, I will have decided that I am prepared to allowmy child to participate in both the activity, and in aspects of the activity, including transportation to and from the activity. I also confirm that I have and will have spoken with my child about these risks and expectations, and that I am confident that they will understand them.

My signature below indicates that I have read and understood this information and consent to:

_____(participant name) participating in the land-base program.

_____ _____

SIGNATURE OF PARTICIPANT DATE

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

_____

SIGNATURE OF WITNESS

_____

SIGNATURE OF NNHC PERSONNEL

NIMKEE NUPIGAWAGAN HEALING CENTRE

Consent to the Disclosure, Transmittal and/or Examination of School Records and/or Information

I, _____ (PRINT NAME OF STUDENT)

Of: **Nimkee Nupigawagan Healing Centre 20850**
Muncey Road PO Box 381 R.R.#1
Muncey, ON N0L 1Y0

Hereby consent to the disclosure of transmittal to, or the examination by the following:

- Nimkee Staff
- Education Workers

In respect of

_____ _____
STUDENT NAME **DATE OF BIRTH**

For the purposes of Educational Support/Planning

Description of Information to be disclosed:

- Education records
- Records/Reports compiled in Ontario Student Records (OSR)
- Any other pertinent information regarding student progress

This consent is valid for 1 year from the date signed: _____
DATE

I understand that I may revoke this consent in writing at any time before the duration of the consent expires, except where action has already been taken in reliance on the authorization.

_____ _____
SIGNATURE OF STUDENT DATE

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

_____ _____
SIGNATURE OF WITNESS DATE

NIMKEE NUPIGAWAGAN HEALING CENTRE

SELF-REPORT MEDICAL HISTORY FORM

FULL NAME	
DATE OF BIRTH	
GENDER	
FOR EMERGENCY	

PLEASE CHECK **Y** OR **N** FOR EACH CONDITION BELOW

CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N
Allergies	☐	☐	Bronchitis	☐	☐	Head Injury	☐	☐	High or low Blood Pressure	☐	☐
Chills	☐	☐	Joint Problems	☐	☐	Seizures	☐	☐	Fever	☐	☐
Sinusitis	☐	☐	Hemorrhoids	☐	☐	Back Pain	☐	☐	Kidney Stones	☐	☐
Paralysis	☐	☐	Dizziness	☐	☐	Ear Infections	☐	☐	Excessive Fatigue	☐	☐
Anemia	☐	☐	Chest Pain	☐	☐	Heart Disease	☐	☐	Chronic Swelling	☐	☐
Diabetes	☐	☐	Cancer	☐	☐	Tremors	☐	☐	Shortness of breath	☐	☐
Thyroid	☐	☐	Convulsions	☐	☐	Vomiting	☐	☐	Sexually Transmitted Disease	☐	☐
Anxiety	☐	☐	Meningitis	☐	☐	Epilepsy	☐	☐	Frequent Urinary TractInfections	☐	☐
Eczema	☐	☐	Depression	☐	☐	Chronic Cough	☐	☐	Sickle Cell	☐	☐
Arthritis	☐	☐	Constipation	☐	☐	Chronic Colds	☐	☐	Diarrhea	☐	☐
Nausea	☐	☐	Fainting	☐	☐	Pneumonia	☐	☐	Hernia	☐	☐
Insomniaa	☐	☐	Dizziness	☐	☐	Malaria	☐	☐	Heartburn	☐	☐
Asthma	☐	☐	Nervousness/panic	☐	☐	Appendectomy	☐	☐	Ulcers	☐	☐

Are you allergic to any foods, medications, or other substances? YES ☐ NO ☐
If yes, please list: _____

*The Medical Form must be completed by the Parent/Participant (Page 1) and the Physical form (Page 2), completed by a doctor or nurse practitioner. Forms may be returned to our office, via: FAX, MAIL, OR HAND DELIVERED. Please use theCONFIDENTIAL disclaimer to return a copy this form, and all other necessary forms.

RETURN COMPLETED FORM TO:
Leroy Cornell Nimkee NupiGawagan Healing Centre Fax: 519-264-1552or email to: continuouscare@nimkee.org

NIMKEE NUPIGAWAGAN HEALING CENTRE

PHYSICAL EXAMINATION FORM

PATIENT FULL NAME: _____ DOB: _____ TODAY'S DATE: _____

EVALUATIONS

VITAL SIGNS			LABORATORY RESULTS AND IMMUNIZATIONS REPORT		
	Normal	**Abnormal**		**Normal**	**Abnormal**
Blood Pressure			Hct _____		
Temperature			Hgb _____		
Pulse			*Fasting Blood Glucose*		
Weight			*Urinalysis*		
Height			**Required Vaccinations**		
Mood			*Varicella (Chickenpox)*	☐	
Recommended Vaccinations HPV _____ ☐ Covid-19 (Pfizer, Moderna) _____ ☐ (Client – please attach copy of vaccination)			*Tetanus (Td/Tdap)*	☐	
			MMR	☐	
			Covid Vaccinations: ***Lots/Date:***	☐	

GENERAL APPEARANCE

	Normal	**Abnormal**		**Normal**	**Abnormal**
Skin			*Respiratory*		
Eyes			*Lungs*		
Ears			*Gastrointestinal*		
Nose			*Genitalia*		
Throat			*Lymphatic*		
Cardiovascular B/P			*Extremities*		
Chest			*Neurological*		
Throat/Dental			*Dental*		
Abdomen			*Muscular Skeletal*		

Visual Acuity: Corrected Vision: Yes ☐ No ☐ (Glasses ☐ Contacts ☐ Surgery ☐)

Mental Health Issues: Yes ☐ No ☐

List all known Allergies: _____

Physical Activity Restriction recommended? Yes ☐ No ☐

List all current medications prescribed: _____

History of Surgery/Hospitalization: _____

_____ _____ _____

PHYSICIAN/NP SIGNATURE DATE LICENSE # OR CLINIC STAMP

NIMKEE NUPIGAWAGAN HEALING CENTRE

STANDING MEDICATION ORDERS

The following are common over the counter medications that are used at Nimkee NupiGawagan Healing Centre. If _____ requests any of the following over the counter medication, they are permitted to take according to package directions.

Medication	Dose	Use	Medical Ingredient
TYLENOL Extra-Strength (Acetaminophen)	**12 years and older:** take one (1) tablet every 4-6 hours. If pain does not respond to one (1) tablet take two (2) tabletsat next dose. ***Do NOT exceed more than eight (8) tablets inone day.*** (As directed on package).	Relief of headache pain, arthritis pain, muscle aches and sprains, menstrual cramps, the aches, and pains due to fluand fever.	Acetaminophen 500mg
ADVIL (Ibuprofen)	**12 years and older:** Take one (1) to two (2) tablets everyfour (4) hours. ***Maximum daily dose six (6) tablets.*** (As directed on package).	Temporary relief of menstrual pain, toothache, minor aches and pains in muscles, bones and joints, fever and headache and pain due to arthritis or rheumatism.	Ibuprofen200mg
BENADRYL Allergy ULTRATAB Tablets	**12 years and older:** Take one (1) to two (2) tablets everyfour (4) to six (6) hours. **Do NOT take more than six (6) times in 24-hours.** (As directed on package).	Fast acting relief from allergies and allergic reactions: sneezing, itchy, wateryeyes, runny nose, skin itch, hives	Diphenhydramine HCl25mg
BENYLIN Extra Strength ChestCough & Cold	**12 years and older:** Take two (2) tsp. every six (6) hours.**Maximum of eight (8) tsp. per day.** (As directed on the package).	Relieves: Coughs, stuffy nose, chest congestion, and sore throat	Menthol from Menthactin 15mg Dextromethorphan HBr 15mg Pseudoephedrine HCl 30mg Guaifenesin 200mg
Extra StrengthTUMS	Chew two (2) to three (3) tablets as needed. **Maximum often (10) tablets a day.** (As directed on the package).	Fast, effective relief from heartburn,	Calcium Carbonate750mg
HALLS Cherry Cough Lozenges	**5 years and older**: Dissolve one (1) drop slowly in the mouth. Repeat every two (2) hours as needed. (As directedon package)	Temporary relieves cough due to a cold, and occasional minor irritation or sore throat.	Menthol7mg
Pepto-Bismol Extra Strength	**Adults:** two (2) tablespoons (30 mL) every hour as needed.**Children 10 to 14 years**: three (3) teaspoons (15 mL) every hour as needed. ***Maximum of four (4) doses in a 24-hour period.*** (As directed on package).	Relief for: nausea, heartburn, indigestion, upset stomach, diarrhea	Bismuth Subsalicylate 35.2 mg/mL
GRAVOL	12 years and older: take one (1) to two (2) tablets every four (4) hours as needed. **Maximum of eight (8) tablets in24-hours.** (As directed on package).	Prevention and treatment of nausea, vomiting, and dizziness	Dimenhydrinate U.S.P 50mg
Midol	Adults and children 12 years and over: take 1 capsule every 4 to 6 hours while symptoms persist if pain or feverdoes not respond to 1 capsule, 2 capsules may be used do not exceed 6 capsules in 24 hours, unless directed by a doctor	For the temporary relief of these symptoms associated with menstrual periods:	Acetaminophen 500 mg + Caffeine60 mg + Pyrilamine maleate 15 mg
Topical Medication	**Directions**	**Use**	**Medical Ingredient**
POLYSPORIN Plus pain relief creamHEAL-FAST Formula	1. Clean the affected area 2. Apply POLYSPORIN to the affected area 1-3 times daily 3. Cover the affected area (Asdirected on package)	Prevents infection	10,000 units Polymyxin B (as Sulfate), 0.25mg Gramicidin, 50mg Lidocaine Hydrochloride
VICKS VAPORRUB	1. Rub a thick layer on chest and throat or rub on sore, achingmuscles. 2. Cover with a warm, dry cloth if desired. 3. Keep clothing loose about throat/chest to help vapors reach the nose/mouth. Repeat up to three times per 24 hours or as directed bydoctor. (As directed on package)	On chest and throat, temporarily relievescough due to common cold On muscles and joints, temporarily relieves minor aches and pains	Regular: Camphor 4.73% Eucalyptus oil 1.2% Menthol 2.6%
AlcoholSwabs	Rub skin briskly in a circular motion from injection siteoutward. (As directed on package)	Antiseptic skin cleaner for use prior of injection	Isopropyl Alcohol 70% v/v USP

****Note: Please circle all medication name youth is approved to have administered to them**

_____, was seen by the below signed , on the date below and is approved to take the above medication(s).

_____ _____

PHYSICIAN **DATE**

PRINT FORM

SAVE FORM RESET FORM

NIMKEE NUPIGAWAGAN HEALING CENTRE

AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIBED MEDICATION BY Client/Participant

Form to be completed by a parent/guardian to request authorization for client/participant to self-administer a prescription medication while in treatment.

Form must be reviewed and, if there are no changes to the medication, an updated parent/guardian signature is required

This request will only be considered if:

(a) The medication is prescribed by a regulated health care provider.
(b) The administration of a prescribed medication on either a routine or emergency basis is necessary for the client/participant; and
(c) It is appropriate for the client/participant to self-administer the prescribed medication.

A. To be Completed by Parent/Guardian (please print):

Name of Client/participant:		Client's/Participants Date of Birth:	
Name of Parent/Guardian:			
Address:			
Home Telephone:		Daytime Telephone	
Cell Phone:		Email:	

Contact in Case of Emergency:			
1. Name:		Telephone	
2. Name:		Telephone	

Prescribing Physician Information:			
Name:		Telephone	
Physician's Office Address:			

A. If medication is only to be administered in the event of an emergency, please list:

Prescribed Medication:		Dosage:	
Circumstances under which the medication should be administered:			
Any indicators that the medication should not be administered:			
What is the expected result of administering the medication:			
What are the possible side effects of this medication?			
What, if any, are the effects of a delay in the administration of the medication or a missed dosage?			
Any additional instructions?			
Instructions for storage/refrigeration:			

☐ A Plan of Care has been co-created with Nimkee NupiGawagan Healing Centre.

B. If medication is to be administered routinely, please list:

Prescribed Medication				
Dosage				
Time of Administration				
Possible side effects, including effects of a delayed or missed dosage				
Additional instructions (e.g., storage)				

In submitting this request, I/we acknowledge and agree that:

(a) If participant's medication is to be stored at Nimkee NupiGawagan Healing Centre, I/we are solely responsible for providing the prescribed medication in an adequate supply for up to two weeks.

(b) Any medication will be provided in the original container(s) from the pharmacist,which will clearly display:
   (i) the name of the Participant,
   (ii) the name of the medication,
   (iii) the dosage,
   (iv) the name of prescribing regulated health care provider,
   (v) frequency of administration, and
   (vi) date of expiry.

(c) Because I/we are giving our permission for the client/participant to self-administer the medication.

I/we acknowledge and agree that the personal information provided on this Form and otherwise in support of our child will be disclosed as necessary to Nimkee NupiGawagan Healing Centre.

☐ A copy of the pharmacist's instructions for the administration of the prescribed medication is attached.

I acknowledge that I am aware and understand my child's medical condition and the risks associated with its care and emergency treatment.

_____	_____
Parent/Guardian Signature	Date
_____	_____
NNHC Staff	Date
_____	_____
Physician /NP Signature, License # and or Clinic Stamp	Date
_____	_____
Youth Signature	Date