12 to 17 Years Old

2024

Intake for Treatment Package

Nimkee

Nupigawagan

Healing Centre

NIMKEE NUPIGAWAGAN HEALING CENTRE

GENERAL INFORMATION

PARTICIPANTS NAME:	DATE OF BIRTH:	AGE:
PARTICIPANTS 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 participant?	Number of sessions:	
Will you continue to support your participant through and after their stay at the Treatment Facility? YES ☐ NO ☐		
PHOTOGRAPH OF PARTICIPANT (can be taken later upon entry)		

Participant 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 live 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 youth:

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 _____

Participant's age at time of separation?____Participant'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:

Participant 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:

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

What are three strengths that best describe yourself?

How do you spend your free time?

What activities do you enjoy doing the most?

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

Does your youth adhere to curfew? YES ☐ NO ☐

Does your youth date? YES ☐ NO ☐

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

Is it of concern to you?

NIMKEE NUPIGAWAGAN HEALING CENTRE

PARTICIPANT INFORMATION - CONTINUED

Participant's 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

Participant 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).

PARTICIPANT'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

PARTICIPANT 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, outpatient clinic, 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/IndigenousSupport Services?

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

NIMKEE NUPIGAWAGAN HEALING CENTRE

GENDER AND SEXUAL ORIENTATION

Nimkee is a gender-separated service. Respectful of gender diversity, we will work with participants 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, intramuscular, 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

PARTICIPANT HEALTH

Participant 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:

PARTICIPANT 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:

NIMKEE NUPIGAWAGAN HEALING CENTRE

PARTICIPANT 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 orcontrol 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 disorder 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:

NIMKEE NUPIGAWAGAN HEALING CENTRE

PATICIPANT 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 injury related 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:

NIMKEE NUPIGAWAGAN HEALING CENTRE

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

EDUCATIONAL HISTORY

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

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

Do you want help with an educational plan upon completion of the 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 tothe 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 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 e.g. 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 the following individuals:

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

PARTICIPANT 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 participant 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 healing 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 information concerning 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 healing 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 participant & Nimkee Nupigawagan 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 PARTICIPANT	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

PARTICIPANT 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 participant (parent/guardians).

Services such as accommodation (room and general supplies for the comfortable stay of the participant), 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, are considered part of the youth treatment work plan.

Acknowledgement:

SIGNATURE OF PARTICIPANT	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

Participant NAME:_____ DATE:_____

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

Acknowledgement:

SIGNATURE OF PARTICIPANT	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 education program for participants.

We also ask that you provide us with some areas of interest to look into courses and programs available for you while you are at Nimkee Nupigawagan Healing Centre.

Subjects of Interest (Things you enjoy learning about):

NIMKEE NUPIGAWAGAN HEALING CENTRE

LAND BASED ACTIVITIES 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 participants. There is an exhaustive list of mandatory training that employees complete, and each employee has vulnerable sector checks. In addition, all employees have been 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 youth to participate in. 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 participants 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 participant. However, as with 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;
- participants must sometimes rely upon and trust their lives to technical equipment such as certified ropes & safety gear, life jackets, etc.
- wild animals may be present in some of the areas in which wetravel.

As a consequence of Nimkee Nupigawagan land-based program, each parent, guardian and participant must 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 staff 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 at Nimkee Nupigawagan Healing Centre.

NIMKEE NUPIGAWAGAN

I understand that outdoor activities may present to my youth/child a wide variety of risks, hazards and conditions, not all ofthem easily foreseeable, which could result in loss, damage or injury to my youth/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 that the 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 youth's behavioural characteristics, physical health, and abilities, whether my youth should be allowed to participate in the Land Based Program, which is essential part of the program.

I understand that my youth/child will be expected to uphold the standards of behaviour expected of all participants in any land-based program, and that participants 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 youth no longer participate in the activity, with the understanding that this is in the best interests of all participants. Participants will be expected to act with responsibility and care for themselves and for others on the activity. Participants are 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 youth/child to withdraw from the remainder of the program.

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

I give permission for program staff to administer first aid treatment to my youth/child and acknowledge that I will be responsible for any medical or other charges in connection with my youth's/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 youth's/child's participation therein, I will have decided that I am prepared to allow my youth/child to participate in boththe 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 youth/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-based 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 PARTICIPANT DATE

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE

_____ _____
SIGNATURE OF WITNESS DATE

INFORMATION FOR PARTICIPANTS

Nimkee requires medical information about you to ensure a safe stay in residence.

We request that you have a medical report completed by your usual primary care provider.

A *primary care provider* is an advanced health care practitioner who knows you well. You may know them as a family doctor, a family physician, a general practitioner, or a nurse practitioner. You may see them at a family health team, a northern nursing station, or a walk-in clinic that you go to regularly.

Do you have a primary care provider?

☐ **YES**. Contact the office of your primary care provider and let them know you need to have a medical assessment within 30 days of your expected arrival date. Take the 4-page *medical report* to your appointment. Return it to Nimkee on completion.

☐ **NO**. Fill out the **4-page *medical self-report*** and return it with your application.

☐ **UNCERTAIN**. Speak to your intake coordinator.

The information will help Nimkee staff to understand your health care needs. There are no on-site staff with a medical or nursing background, though local off-site support may be available from the *Southwest Ontario Aboriginal Health Access Centre (SOAHAC)* on an as-needed basis.

How To Stay On Your Medication While In Residence

All medication (including those available over-the-counter) and related supplies will be kept in a secure area by Nimkee staff and will only be dispensed for observed self-dosing according to the prescription. **NOTE**: Always bring critically important medications (such as an Epi-pen or a rescue inhaler), even if you do not use them often and even if you think you will not need them.

There are a couple ways to stay on your regular medications while in residence:

OPTION 1 - BRING EVERYTHING

Arrange with your home pharmacy to dispense enough medication and related supplies to cover your entire stay in residence, if possible. (Note: most insurers will only allow dispensing of 90- or 100-days' worth of medication at a time, so this may not always be possible depending on when it was last dispensed.) Bring everything with you **in its original packaging with labels from the pharmacy**. Staff will store your medications on arrival.

OPTION 2: TRANSFER YOUR PRESCRIPTIONS

If you do not arrive with enough medication and related supplies to cover your entire stay, Nimkee staff will assist you to contact your home pharmacy to have the balance of your prescriptions transferred to the local pharmacy:

CDS Pharmacy in Mount Brydges tel 519-289-264-2000 fax 519-264-2396

(When you return home, you will need to contact your home pharmacy to have any remaining balances transferred *back from* CDS Mount Brydges.)

MEDICAL REPORT – to be completed by your primary care provider

IF YOU DO NOT HAVE A PRIMARY CARE PROVIDER GO TO MEDICAL SELF-REPORT

Dear Primary Care Provider,

Your patient is applying to attend Nimkee Nupigawagan Healing Centre's program for youth with substance use disorder (or those at high risk). We are requesting medical information so that we can provide your participant with safe care during their stay of up to 12 weeks. **(Please note: If your participantis younger than age 18, a medical assessment within 30 days of arrival to healing care is REQUIRED by the Ministry.)**

CARE WHILE IN RESIDENCE Nimkee is a non-medical healing centre. There are no on-site staff with a medial or nursing background. Local off-site support may be available from the *Southwest Ontario Aboriginal Health Access Centre (SOAHAC)* on an as-needed basis.

☐Yes ☐No Are you available for virtual care/consultation while your participant is in residence?

FITNESS TO PARTICIPATE This is a up to 12-week healing treatment program involving land-based and traditional Indigenous activities. This may include hiking, swimming, paddling, exposure to smudging,the weather, and natural elements. Youth are expected to participate in sharing circles, counselling, and age-appropriate school or work preparation activities.

Which statement best describes your participant's situation?

☐ My participant is medically fit to participate fully in the program.

☐ My participant has medical limitations to participating in the program. Their limitations are:

(Nimkee staff may seek clarification to determine whether they can accommodate the limitations noted.)

SUBSTANCE USE		
substance(s) used in last 3mo	how much & how often?	last use? or planned quit date?

Participants are encouraged to withdraw from substances prior to arrival, especially if there is a chance that their withdrawal will require medical management. Please discuss this with your participant and indicate which course of action you recommend.

☐ to access medically supervised withdrawal management prior to arrival at the healing centre or
☐ to attend Nimkee given their LOW risk of severe withdrawal

☐Yes ☐No I have prescribed medications to alleviate anticipated withdrawal symptoms.
The prescription clearly indicates under which circumstances the medication should be dispensed.

MEDICATION While in residence at Nimkee, medications are kept secured by non-medical staff and are only distributed for observed self-dosing according to the prescription.

Does your participant take any prescribed medications? ☐Yes ☐No

participant's pharmacy:

medication is covered by: ☐ NIHB (IA) ☐ ODB ☐ OHIP+ ☐ private insurance ☐ other

OPTIONAL: The medication list is extensive and/or I prefer to provide a copy. ☐Yes ☐No

medication:	dosage:	condition being treated:	prescribed by:

MEDICAL REPORT – to be completed by your primary care provider

☑ I have ensured that there are enough refills to last until their anticipated discharge date.			
☐Yes ☐No Must any of these medications always be kept in the personal possession of the participant? (e.g. rescue inhaler) If yes, which one(s)?			
☐Yes ☐No Are any of these medications given by injection? If yes, the medication is given ☐ by self-injection or ☐ by a health care professional (Nimkee will arrange for this to be done through SOAHAC)			
☐Yes ☐No Do they require supplies for diabetic monitoring? ☐ glucometer ☐ Libre ☐ Dexcom			
☐Yes ☐No Is your participant using traditional medicines?			
OTC MEDICATION - Nimkee staff cannot dispense any non-prescribed medication, even those available OTC. Please complete the *Individualized Medication Orders* for prn use on page 4.			

VACCINATION Nimkee strongly encourages vaccination according to their province's publicly funded immunization schedule. Which statement(s) best describe your participant's situation?
☐ My participant's current vaccination record is attached ☐ My participant's lab report of equivalent titres is attached ☐ There is insufficient documentation of vaccination or titres to draw conclusions about immunity.
☐ My participant is vaccinated per schedule and no catch up is required or ☐ My participant is partially vaccinated and ☐ We will complete a catch-up schedule prior to arrival at Nimkee or ☐ We will not have time to complete a catch-up schedule prior to arrival at Nimkee. ☐ My participant is not fully vaccinated and declines further vaccination.
My participant understands that if there is an outbreak of a communicable disease against which they have not been fully vaccinated, or if there is no available documentation of their vaccination or immunity status, that they may be placed in isolation at Nimkee and/or required to return home.

To help us better understand your participant's medical needs, please complete the remainder of the form.

OPTIONAL*:* My participant's EMR profile is current and includes the same core information as the remainder
of this form. I am choosing to attach a copy of it instead of (or as an addendum to) this form. ☐Yes ☐No

ALLERGIES or adverse reactions to medication or other substances	
Does your participant have allergies? ☐Yes ☐No	If yes, do they require an Epi-pen? ☐Yes ☐No
If yes, to which medication / substance?	What is the reaction? What is the treatment?

PERSONAL HEALTH HISTORY Please list any medical or developmental conditions that may impact their care or their ability to participate in the program.	
childhood	
adolescence	
adulthood	
☐Yes ☐No Does your participant pose a risk of physical harm to self or others?	
☐Yes ☐No Is your participant under the care of a specialist? If yes, who?	
☐Yes ☐No Does your participant need to see a dentist while in residence?	

MEDICAL REPORT – to be completed by your primary care provider

☐Yes ☐No Does your participant need a hearing test?	
☐Yes ☐No Does your participant wear corrective lenses?	
☐Yes ☐No Was your participant's last eye exam > 2 years ago?	
☐Yes ☐No Is your participant on a special diet? If yes, please describe.	
☐Yes ☐No Have you addressed the need to test for pregnancy or STI?	
FAMILY HEALTH HISTORY Please list any medical conditions in your participant's family that may be relevant to their care while in residence.	
maternal FHx	
paternal FHx	
siblings / children	
SOCIAL DETERMINANTS OF HEALTH Please briefly describe any significant factors that may affect your participant's ability to attend, participate in, and transition home from treatment. (e.g. housing, income, family status, gender identity, sexuality, education, employment, legal problems)	
OTHER relevant information about my participant's health:	
OPTIONAL: If your participant's access to tests or consultations has been limited by remote/isolated location in the north, we may be able to help arrange for these during their stay in southwestern Ontario (with advanced notice and in consultation with SOAHAC primary care providers.) Do you want to be notified by Nimkee staff if your participant is accepted to the program? ☐Yes ☐No	

participant name - as it appears on health card | preferred name

health card number (9 numbers + 2 letters)

MD / NP - printed name or stamp | MD or NP signature | date

MEDICAL REPORT – to be completed by your primary care provider

Dear Primary Care Provider,

These over-the-counter medications are available on an as-needed basis at Nimkee Nupigawagan Healing Centre. Please indicate which would be appropriate to dispense if requested by your participant.

✓	Medication - oral	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) tablets at next dose. **Maximum eight (8) tablets in one day.**	Relief from headache pain, arthritis pain, muscle aches and sprains, menstrual cramps, aches and pains due to flu and fever.	Acetaminophen 500mg
	ADVIL Regular-Strength (Ibuprofen)	**12 years and older:** Take one (1) to two (2) tablets every four (4) hours. **Maximum daily dose six (6) tablets.** (As directed on package).	Relief from menstrual pain, toothache, minor aches and pains in muscles, bones and joints, fever and headache and pain due to arthritis.	Ibuprofen 200mg
	BENADRYL	**12 years and older:** Take one (1) to two (2) tablets twice daily for one day. **Maximum 4 tablets** to reduce abuse potential. Ongoing allergic symptoms are best treated with Claritin or similar long-acting non-drowsy antihistamine.	Relief from allergic symptom: sneezing, itchy, watery eyes, runny nose, hives	Diphenhydramine HCI 25mg
	CLARITIN	**12 years and older:** Take one (1) tablet once daily. **Maximum one (1) time in 24-hours.** (As directed on package).	Relief from allergic symptoms: sneezing, itchy watery eyes, runny nose, skin itch, hives	Loratadine 10mg
	BENYLIN Extra Strength Chest Cough & Cold	**12 years and older:** Take two (2) teaspoons (10 mL) every six (6) hours. **Maximum of eight (8) teaspoons (40 mL) per day.** (As directed on the package).	Relief from coughs, stuffy nose, chest congestion, and sore throat	Menthol 15mg, Dextromethorphan HBr 15mg, Pseudoephedrine HCI 30mg , Guaifenesin 200mg
	TUMS Extra Strength	**12 years and older:** Chew two (2) to three (3) tablets as needed. **Maximum of ten (10) tablets a day.**	Relief from heartburn	Calcium Carbonate 750mg
	HALLS Cough Lozenges	**5 years and older**: Dissolve one (1) lozenge slowly in the mouth. Repeat every two (2) hours as needed. (As directed on package)	Relief from cough due to a cold, and occasional minor irritation or sore throat.	Menthol 7mg
	PEPTO-BISMOL Extra Strength	**12 years and older:** Use two (2) tablespoons (30 mL) every hour as needed. **Maximum of four (4) doses in a 24-hour period.** (As directed on package).	Relief from nausea, heartburn, indigestion, upset stomach, diarrhea	Bismuth Subsalicylate 35.2 mg/mL
	GRAVOL	**12 years and older:** Take half (0.5) to one (1) tablets every four (4) hours as needed. **Maximum of eight (8) tablets in 24-hours. Maximum 2 days.** Nausea lasting beyond this timeframe should be evaluated by a health care professional.	Relief from nausea, vomiting, and dizziness	Dimenhydrinate 50mg
	MIDOL	**12 years and older: Take one (1) capsule every 4 to 6 hours while symptoms persist. If pain or fever does not respond to one (1) capsule, two (2) capsules may be used. Maximum 6 capsules in 24 hours. (As directed on package).**	Relief from symptoms associated with menstrual periods such as cramps, headache, bloating, backache, water-weight gain, muscle aches and fatigue	Acetaminophen 500 mg, Caffeine 60 mg, Pyrilamine maleate 15 mg
	MELATONIN	**12 years and older: Take one (1) tablet 15-30 minutes before going to bed when needed. Maximum two (2) tablets in 24-hours. (As directed on package).**	Relief from insomnia due short term sleep disruption due to jet lag / travel, major life disruptions. **Not effective beyond 5 days.**	Melatonin 3-5mg
	POLYSPORIN Complete	Clean the affected area then apply POLYSPORIN to the affected area one (1) - three (3) times daily. Cover the affected area (As directed on package)	Relief from pain and prevents infections	Polymyxin B Sulfate 10,000 units, Bacitracin Zinc 500mg, Gramicidin 0.25mg, Lidocaine Hydrochloride 50mg
	VICKS VAPORRUB Regular	Rub a thick layer on chest and throat or rub on sore, aching muscles then cover with a warm, dry cloth if desired. Keep clothing loose about throat/chest to help vapors reach the nose/mouth. Repeat up to three (3) times per 24 hours or as directed by doctor. (As directed on package)	Chest and throat: Relief from cough due to common cold Muscles and joints: Relief from minor aches and pains	Camphor 4.73%, Eucalyptus oil 1.2%, Menthol 2.6%
	Alcohol Swabs	Rub skin briskly in a circular motion from injection site outward. (As directed on package)	Antiseptic skin cleaner for use prior of injection	Isopropyl Alcohol 70% v/v USP
	VOLTAREN Regular Strength	Apply up to four (4) grams to each affected area up to four (4) times a day. **Maximum sixteen (16) grams daily for one area and thirty-two (32) grams daily for the whole body.** (As directed on package).	Relief from muscle aches and pains	Diclofenac 1.16%
	RUB A535	Apply a thin layer to the affected area three (3) to four (4) times daily as needed. (As directed on package).	Relief from muscle aches and pains	Methyl Salicylate 21%, Camphor 4%, Menthol 3%, Eucalyptus Essential Oil 0.75%

participant name - as it appears on their health card birth date

☑ *This participant is approved to take the medications as indicated above if requested.*

MD / NP - printed name or stamp MD or NP signature date

NIMKEE NUPIGAWAGAN HEALING CENTRE

MEDICAL SELF-REPORT

full name - as it appears on your health card | preferred name

birth date YYYY-MM-DD | health card number (9 numbers + 2 letters)

☑ **I am choosing to complete the medical self-report because I do <u>not</u> have a primary care provider. I promise to provide true and complete information to the best of my ability.**

participant signature | date

ALLERGIES or adverse reactions to medication or other substances	
Do you have any allergies? ☐Yes ☐No	If yes, do you require an Epi-pen? ☐Yes ☐No
If yes, to which medication / substance?	What is the reaction? What is the treatment?

MEDICATION While in residence at Nimkee, medications are kept secured by non-medical staff and are only distributed for observed self-dosing according to the prescription.
Do you take any prescribed medications? ☐Yes ☐No

If yes, my pharmacy is:

My medication is covered by: ☐ NIHB (IA) ☐ ODB ☐ OHIP+ ☐ private insurance ☐ other

OPTIONAL: I am uncertain about the details of my medications ~or~ it is a long list. Instead of completing the section below, I am enclosing a printed medication list from my pharmacy. ☐Yes ☐No

medication:	dosage:	condition being treated:	prescribed by:

☐Yes ☐No Are any of these given by injection? If yes, the medication is given:
- ☐ by self-injection <u>or</u>
- ☐ by a health care professional (Nimkee will arrange for this to be done through SOAHAC)

☐Yes ☐No Do you require supplies for diabetic monitoring? ☐ glucometer ☐ Libre ☐ Dexcom

OTC MEDICATION - If you regularly use any over-the-counter medications, list them on page 4.
☑ *I am aware that Nimkee staff cannot dispense any non-prescribed medication to me, even if it is available over-the-counter. If I request such medication after arrival, Nimkee can arrange for me to be assessed by a local primary care provider to determine which medications are safe for me (page 4).*

☐Yes ☐No Are you using traditional medicines?

NIMKEE NUPIGAWAGAN HEALING CENTRE

SUBSTANCE USE – which non-prescribed drugs/substances did you use regularly in the last 3 months?		
which substance?	how much & how often?	last use? or planned quit date?
☑ *I am aware that Nimkee staff may contact me to further assess my risk of withdrawal that may require medical management.*		

VACCINATION Nimkee strongly encourages vaccination according to your province's publicly funded immunization schedule.
Which statement best describes your situation? ☐ I am attaching a copy of my current vaccination record. ☐ I have had some vaccinations, but I do not have a record. My records may be available at this clinic: _____ ☐ I am unvaccinated.
Which statement best describes your willingness to receive catch-up vaccinations? ☐ I am willing to receive catch-up vaccines if recommended. ☐ I am <u>not</u> willing to receive catch-up vaccines.
☑ *If there is an outbreak of a communicable disease against which I have not been fully vaccinated, <u>or</u> if there is no available documentation of my vaccination status, I understand that I may be placed in isolation at Nimkee and/or required to return home.*

PERSONAL HEALTH HISTORY Please list any medical conditions you have had in the past, or currently have. (If you don't know the medical terms, just describe it in your own words.)	
infancy	
childhood	
adolescence	
adulthood	
☐Yes ☐No Are you under the care of a specialist? If yes, who?	
☐Yes ☐No Have you ever had surgery? If yes, which procedure?	
☐Yes ☐No Do you have any current dental concerns?	
☐Yes ☐No Do you feel that you need a hearing test?	
☐Yes ☐No Do you wear corrective lenses (glasses or contacts)?	
☐Yes ☐No Was your last eye exam more than 2 years ago?	
☐Yes ☐No Are you on a special diet? If yes, please describe.	
☐Yes ☐No Do you want testing for pregnancy or sexually transmitted infection after arrival?	
☐Yes ☐No Do you have any longstanding symptoms or health problems that have <u>not</u> yet been investigated due to lack of primary care provider? If yes, please describe them in your own words.	

NIMKEE NUPIGAWAGAN HEALING CENTRE

FAMILY HEALTH HISTORY Please list any significant medical conditions that you are aware of in your biologic family members. (If you don't know the medical terms, just describe it in your own words.)	
mother	
mother's mother	
mother's father	
father	
father's mother	
father's father	
siblings	
children	

SOCIAL DETERMINANTS OF HEALTH Please briefly describe any significant factors that may affect your ability to attend, participate in, and transition home from treatment. (e.g. housing, income, family status, gender identity, sexuality, education, employment, legal problems)

FITNESS TO PARTICIPATE This is a 12-week healing treatment program involving land-based and traditional Indigenous activities. This may include hiking, swimming, paddling, exposure to smudging, the weather, and natural elements. Youth are expected to participate in sharing circles, counselling, and age-appropriate school or work preparation activities. Which statement best describes your situation?	
☐ I am age 18-25	☐ I am confident that I am medically fit to participate fully in the program.
	☐ I have medical limitations to participating in the program. My limitations are:
☐ I am age 12-17	☐ I am confident that I am medically fit to participate fully in the program.
	☐ I have medical limitations to participating in the program. My limitations are:
	☐ *I understand that because I am under 18 and I did <u>not</u> have a medical assessment within 30 days prior to arrival, the Ministry requires me to have this done within 72h after arrival. Nimkee will arrange this on my behalf.*
(Nimkee staff may seek clarification to determine whether they can accommodate the limitations noted.)	

OTHER information about my medical needs:

NIMKEE NUPIGAWAGAN HEALING CENTRE

✓	Medication - oral	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) tablets at next dose. **Maximum eight (8) tablets in one day.**	Relief from headache pain, arthritis pain, muscle aches and sprains, menstrual cramps, aches and pains due to flu and fever.	Acetaminophen 500mg
	ADVIL Regular-Strength (Ibuprofen)	**12 years and older:** Take one (1) to two (2) tablets every four (4) hours. **Maximum daily dose six (6) tablets.** (As directed on package).	Relief from menstrual pain, toothache, minor aches and pains in muscles, bones and joints, fever and headache and pain due to arthritis.	Ibuprofen 200mg
	BENADRYL	**12 years and older:** Take one (1) to two (2) tablets twice daily for one day. **Maximum 4 tablets** to reduce abuse potential. Ongoing allergic symptoms are best treated with Claritin or similar long-acting non-drowsy antihistamine.	Relief from allergies and allergic reactions: sneezing, itchy, watery eyes, runny nose, skin itch, hives	Diphenhydramine HCl 25mg
	CLARITIN	**12 years and older:** Take one (1) tablet once daily. **Maximum one (1) time in 24-hours.** (As directed on package).	Relief from allergic symptoms: sneezing, itchy watery eyes, runny nose, skin itch, hives	Loratadine 10mg
	BENYLIN Extra Strength Chest Cough & Cold	**12 years and older:** Take two (2) teaspoons (10 mL) every six (6) hours. **Maximum of eight (8) teaspoons (40 mL) per day.** (As directed on the package).	Relief from coughs, stuffy nose, chest congestion, and sore throat	Menthol 15mg, Dextromethorphan HBr 15mg, Pseudoephedrine HCl 30mg , Guaifenesin 200mg
	TUMS Extra Strength	**12 years and older:** Chew two (2) to three (3) tablets as needed. **Maximum of ten (10) tablets a day.**	Relief from heartburn	Calcium Carbonate 750mg
	HALLS Cough Lozenges	**5 years and older**: Dissolve one (1) lozenge slowly in the mouth. Repeat every two (2) hours as needed. (As directed on package)	Relief from cough due to a cold, and occasional minor irritation or sore throat.	Menthol 7mg
	PEPTO-BISMOL Extra Strength	**12 years and older:** Use two (2) tablespoons (30 mL) every hour as needed. **Maximum of four (4) doses in a 24-hour period.** (As directed on package).	Relief from nausea, heartburn, indigestion, upset stomach, diarrhea	Bismuth Subsalicylate 35.2 mg/mL
	GRAVOL	**12 years and older:** Take half (0.5) to one (1) tablets every four (4) hours as needed. **Maximum of eight (8) tablets in 24-hours. Maximum 2 days.** Nausea lasting beyond this timeframe should be evaluated by a health care professional**.**	Relief from nausea, vomiting, and dizziness	Dimenhydrinate 50mg
	MIDOL	**12 years and older: Take one (1) capsule every 4 to 6 hours while symptoms persist. If pain or fever does not respond to one (1) capsule, two (2) capsules may be used. Maximum 6 capsules in 24 hours. (As directed on package).**	Relief from symptoms associated with menstrual periods such as cramps, headache, bloating, backache, water-weight gain, muscle aches and fatigue	Acetaminophen 500 mg, Caffeine 60 mg, Pyrilamine maleate 15 mg
	MELATONIN	**12 years and older: Take one (1) tablet 15-30 minutes before going to bed when needed. Maximum two (2) tablets in 24-hours. (As directed on package).**	Relief from insomnia due short term sleep disruption due to jet lag / travel, major life disruptions. **Not effective beyond 5 days.**	Melatonin 3-5mg
	POLYSPORIN Complete	Clean the affected area then apply POLYSPORIN to the affected area one (1) - three (3) times daily. Cover the affected area (As directed on package)	Relief from pain and prevents infections	Polymyxin B Sulfate 10,000 units, Bacitracin Zinc 500mg, Gramicidin 0.25mg, Lidocaine Hydrochloride 50mg
	VICKS VAPORRUB Regular	Rub a thick layer on chest and throat or rub on sore, aching muscles then cover with a warm, dry cloth if desired. Keep clothing loose about throat/chest to help vapors reach the nose/mouth. Repeat up to three (3) times per 24 hours or as directed by doctor. (As directed on package)	Chest and throat: Relief from cough due to common cold Muscles and joints: Relief from minor aches and pains	Camphor 4.73%, Eucalyptus oil 1.2%, Menthol 2.6%
	Alcohol Swabs	Rub skin briskly in a circular motion from injection site outward. (As directed on package)	Antiseptic skin cleaner for use prior of injection	Isopropyl Alcohol 70% v/v USP
	VOLTAREN Regular Strength	Apply up to four (4) grams to each affected area up to four (4) times a day. **Maximum sixteen (16) grams daily for one area and thirty-two (32) grams daily for the whole body.** (As directed on package).	Relief from muscle aches and pains	Diclofenac 1.16%
	RUB A535	Apply a thin layer to the affected area three (3) to four (4) times daily as needed. (As directed on package).	Relief from muscle aches and pains	Methyl Salicylate 21%, Camphor 4%, Menthol 3%, Eucalyptus Essential Oil 0.75%

These over-the-counter medications may be available on an as-needed basis at Nimkee Nupigawagan Healing Centre.

If you request non-prescribed medications, Nimkee staff will arrange for you to be reviewed by a local primary care provider to determine which medication is appropriate for you and to complete this form. Do not complete this yourself.

participant name - as it appears on their health card birth date

_____*This participant is approved to take the medications as indicated above if requested.*

MD / NP - printed name or stamp MD or NP signature date

NIMKEE NUPIGAWAGAN HEALING CENTRE

AUTHORIZATION FOR SELF-ADMINISTRATION OF PRESCRIBED MEDICATION BY Participant

Form to be completed by a parent/guardian to request authorization for 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 participant; and
(c) It is appropriate for the participant to self-administer the prescribed medication.

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

Name of participant:		ParticipantsDate 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:			

NIMKEE NUPIGAWAGAN HEALING CENTRE

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:			

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 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/youth 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 youth's medical condition and the risks associated with its care and emergency treatment.

Parent/Guardian Signature	Date
NNHC Staff	Date
Youth Signature	Date