JORDAN'S PRINCIPLE INTAKE FORM
MANITOBA KEEWATINOWI OKIMAKANAK INC

PARENT(S) / LEGAL GUARDIAN / CAREGIVER INFORMATION	
First Name:	Last Name:
First Name:	Last Name:
Relationship to child:	
Address (unit / suite / street)	
Phone number:	Email:
Preferred language:	Family Involved with CFS: ☐ Y ☐ N Name of Agency:

CHILD INFORMATION #1 (if applicable)	
First Name:	Last Name:
Child's Date of Birth (mm/dd/yyyy):	Gender: ☐ M ☐ F ☐ X
Is Child Registered: ☐ Y ☐ N If yes, registration number & band.	If no name of both parents & registration numbers:
Health (MHSC / PHIN)	
School & Grade:	Daycare / Head Start:

CHILD INFORMATION #2 (If applicable)	
First Name:	Last Name:
Child's Date of Birth (mm/dd/yyyy)	Gender: ☐ M ☐ F ☐ X
Is Child Registered: ☐ Y ☐ N If yes, Band & treaty	If not name of both parents & treaty
MB Health (MHSC / PHIN)	
School & Grade:	Daycare / Head Start:

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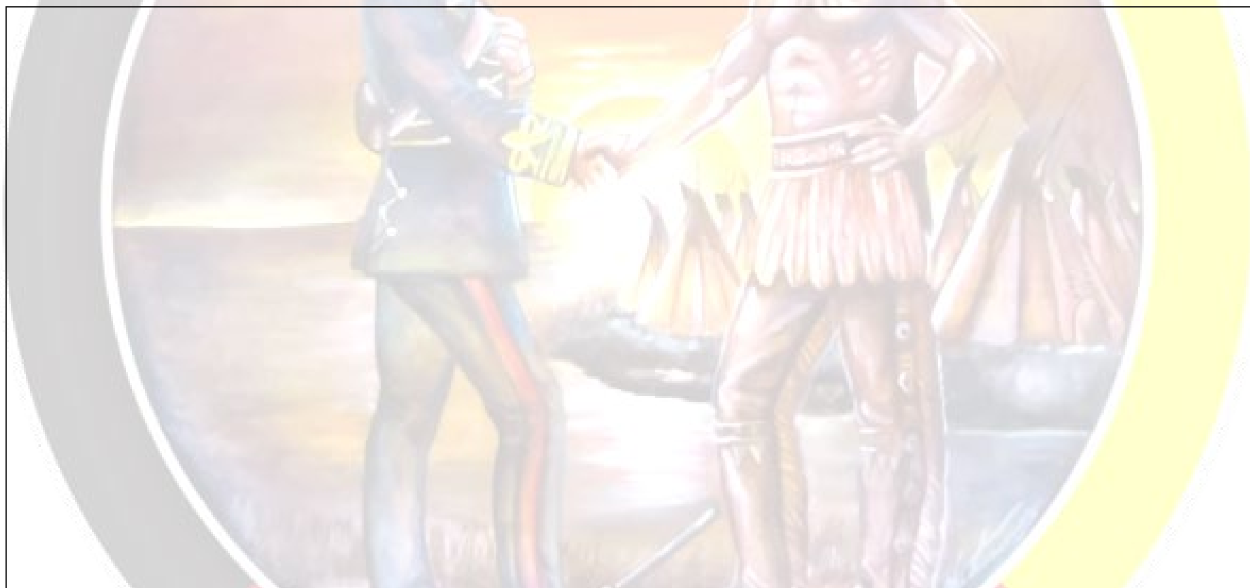
CHILD INFORMATION #3 (if applicable)	
First Name:	**Last Name:**
Child's Date of Birth (mm/dd/yyyy):	**Gender:** ☐ M ☐ F ☐ X
Is Child Registered: ☐ Y ☐ N **If yes, registration number & band.**	**If no name of both parents & registration numbers:**
Health (MHSC / PHIN)	
School & Grade:	**Daycare / Head Start:**

REQUEST INFORMATION



SIGNATURE	
PRINT NAME:	PLEASE SIGN:
VERBAL CONSENT:	DATE OF VERBAL CONSENT:
JP STAFF NAME:	JP STAFF SIGNATURE:
DATE (mm/dd/yyyy):	

ENROLLMENT CONSENT

I ___________________________________ consent to my child's enrollment in Jordan's Principle to access health, social and educational products, services and supports, including assessment and, potentially treatment. The general risks and benefits of enrolling in Jordan's Principle have been explained to me and my child. I understand that discussions regarding risks and benefits will continue over the course of enrollment. I understand that I have/my child has the right to as questions about service and participate in goal setting and clinical planning. My/my child's participation in treatment will be interpreted as ongoing consent. I understand that I/my child can withdraw consent for this service at any time. I understand that doing so would in no way affect my/my child's ability to access service in the future.

SIGNATURE	
PRINT NAME:	PLEASE SIGN:
VERBAL CONSENT:	DATE OF VERBAL CONSENT:
JP STAFF NAME:	JP STAFF SIGNATURE:
DATE (mm/dd/yyyy):	

INFORMATION EXCHANGE CONSENT

SECTION 1. CONSENT TO SHARING OF INFORMATION

I understand that some personal information and/or personal health information may need to be shared for the purpose of assessment, treatment, planning and developing programs and/or strategies that will benefit the individual or family. I understand that personal information or personal health information is disclosed to act in the best interest of the person. I understand that the information shared will be on a need-to-know basis only.

The Personal Health Information Act (PHIA) and the Protecting and Supporting Children (Information Sharing) Act allow service providers to share personal information and/or personal health information with other service providers without consent in certain circumstances. I understand that personal information and/or personal health information may be shared without my consent for the purpose of providing timely and necessary servicers or care.

I understand that each of the participating organizations/agencies listed in Section 2 will maintain confidentiality of the information in accordance with the Freedom of Information and Protection of Privacy Act (FIPPA), the Personal Health Information Act (PHIA), the Privacy Act, the Access to Information Act, the Personal Information Protection and Electronic Document Act (PIPEDA) and any other applicable legislation. I understand that person(s) not authorized under the Act(s) and who wish to receive information, or a copy of a report, are required to obtain consent from the individual or their authorized legal representative or legal guardian.

I ________________________________ consent to the sharing of my/my child's personal information and/or personal health information between organizations/agencies listed in section 2. I understand that I/my child can withdraw this consent at any time. I understand that doing so would in no way affect my/my child's ability to access services in the future.

SIGNATURE	
PRINT NAME:	PLEASE SIGN:
VERBAL CONSENT:	DATE OF VERBAL CONSENT:
JP STAFF NAME:	JP STAFF SIGNATURE:
DATE (mm/dd/yyyy):	