Administrative Procedure: Supporting Students with Prevalent Medical Conditions (Anaphylaxis, Asthma, Diabetes, and/or Epilepsy) in Schools

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1.0. Statement

1.1. The Superior North Catholic District School Board believes that it is a shared responsibility to maintain a safe environment for every student. Supporting students with prevalent medical conditions is one aspect of keeping our students well- being a priority.

2.0. Definitions

2.1. **Anaphylaxis** is a sudden and severe allergic reaction, which can be fatal, requiring medical emergency measures be taken.

2.2. **Asthma** is a chronic, inflammatory disease of the airways in the lungs.

2.3. **Diabetes** is a chronic disease, in which the body either cannot produce insulin or cannot properly use the insulin it produces.

2.4. **Epilepsy** is a neurological condition which affects the nervous system. Epilepsy is also known as a seizure disorder or by many people as convulsions.

2.5. **Healthcare Professional** is a member of a College under the Regulated Health Professions Act, 1991 (e.g., medical doctor, nurse practitioner, registered nurse, **pharmacist).**

2.6. **Healthcare Provider** may be a Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

2.7. **Medical Emergency** is an acute injury or illness that poses an immediate risk to a person's life or long-term health and requires assistance from another qualified person and contact with Emergency Medical Services.

2.8. **Medical Incident** is a circumstance that requires an immediate response and monitoring, as the incident may progress to an emergency requiring contact with Emergency Medical Services.

2.9. **Plan of Care** is a form that contains individualized information on a student with a prevalent medical condition. The Plan of Care for a student with a prevalent medical condition should be co-created, reviewed and/or updated by the parents and/or guardians in consultation with the principal or the principal's designate, designated staff (as appropriate), and the student (as appropriate), during the school year.

2.10. Parents have the authority to designate who is provided access to the Plan of Care. With authorization from parents and/or guardians, the principal or the principal's designate should share the Plan of Care with school staff who are in direct contact with students with prevalent medical conditions and, as appropriate, others who are in direct contact with students with prevalent medical conditions (e.g. food service providers, transportation providers, volunteers).

2.11. Prevalent Medical Condition for the purpose of this document, includes anaphylaxis, asthma, diabetes, and epilepsy.

2.12. Self-Management is a continuum where a student's cognitive, emotional, social and physical capacity and stage of development are determinants of their ability to confidently and independently manage their medical conditions(s). The students' journey to reach their full potential along the self-management continuum is not linear and can require varying levels of support over time. A student's capacity for self- management may be compromised during certain medical incidents, and additional support will be required.

2.13. Students are children in Kindergarten and students in Grades 1 to 12.

2.14. Principal's Designate in this policy is a person who is designated by the board to be in charge of the school in the principal's long term absence.

3.0. Roles and Responsibilities

3.1. Parents and/or Guardians of Children with Prevalent Medical Conditions:

3.1.1. As primary caregivers of their child, parents and/or guardians are expected to be active participants in supporting the management of their child's medical conditions(s) while the child is in school. Parents and/or guardians should:

a. Educate their child about their medical condition(s) with support from their child's health care professional, as needed and as appropriate.

b. Guide and encourage their child to reach their full potential for selfmanagement and self-advocacy.

c. Inform the school of their child's medical condition(s) and co-create the Plan of Care for their child with the principal or the principal's designate.

d. Communicate changes to the Plan of Care, such as changes to the status of their child's medical condition(s) or changes to their child's ability to manage their medical condition(s), to the principal or the principal's designate.

e. Confirm annually to the principal or the principal's designate that their child's medical status is unchanged.

f. Initiate and participate in annual meetings to review their child's Plan of Care.

g. Supply their child and/or school with sufficient quantities of medication and supplies in their original, clearly labelled containers, as directed by a health care professional and as outlined in the Plan of Care, and track the expiration dates if they are supplied.

h. Seek medical advice from a medical doctor, nurse practitioner, or pharmacist, where appropriate In addition, the following roles and responsibilities may be included in policies on prevalent medical conditions.

i. Provide the school with copies of any medical reports or instructions from the student's health care provider.

j. Review all school and board policies related to the management of their child's medical condition(s).

3.2. Students with Prevalent Medical Conditions:

3.2.1. Depending on their cognitive, emotional, social and physical stage of development, and their capacity for self-management, students are expected to actively support the development and implementation of their Plan of Care. Students should:

3.2.2. Take responsibility for advocating for their personal safety and well-being that is consistent with their cognitive, emotional, social and physical stage of development and their capacity for self-management.

3.2.3. Participate in the development of their Plan of Care.

3.2.4. Participate in meetings to review their Plan of Care.

3.2.5. Carry out daily or routine self-management of their medical condition to their full potential, as described in their Plan of Care (e.g. carry their medication and medical supplies; follow school board policies on disposal of medication and medical supplies).

3.2.6. Set goals on an ongoing basis, for self-management of their medical condition, in conjunction with their parent(s) and health care professional(s).

3.2.7. Communicate with their parent(s) and/or guardian(s) and school staff if they are facing challenges related to their medical conditions(s) at school.

3.2.8. Wear medical alert identification that they and parent(s) and/or guardians deem appropriate.

3.2.9. If possible, inform school staff and/or their peers if a medical incident or a medical emergency occurs.

3.3. School Staff

3.3.1. School staff should follow the school board's policies and the provisions in their collective agreements related to supporting students with prevalent medical conditions in schools. School staff should:

3.3.2. Review the contents of the Plan of Care for any student with whom they have direct contact.

3.3.3. Participate in training, during the instructional day, on prevalent medical conditions, at a minimum annually, as required by the school board.

3.3.4. Share information on a student's signs and symptoms with other students, if the parents give consent to do so and as outlined in the Plan of Care and authorized by the principal in writing.

3.3.5. Follow school board strategies that reduce the risk of student exposure to triggers or causative agents in classrooms, common school areas, and extra-curricular activities in accordance with the student's Plan of Care.

3.3.6. Support a student's daily or routine management, and respond to medical incidents and medical emergencies that occur during school, as outlined in board policies and procedures.

3.3.7. Support inclusion by allowing students with prevalent medical conditions to perform daily or routine management activities in a school location (e.g., classroom), as outlined in their Plan of Care, while being aware of confidentiality and the dignity of the student.

3.3.8. Enable students with prevalent medical conditions to participate in school to their full potential, as outlined in their Plan of Care.

3.4. In addition, the following roles and responsibilities may be included in policies on prevalent medical conditions:

3.4.1. Collaborate with parent(s) and/or guardians in developing transition plans for students with Prevalent Medical Conditions, as appropriate.

3.4.2. Maintain log of administration of medication.

3.4.3. Notify the principal or principal's designate if they become aware of the expiry date on medication(s) has been reached.

3.5. Principal or Principal's Designate, in addition to the responsibilities outlined under "School Staff", the principal and/or designate will:

3.5.1. Clearly communicate to parents and appropriate staff the process for parents to notify the school of their child's medical condition(s), as well as the expectation for parents and/or guardians to co-create, review, and update a Plan of Care with the principal or the principal's designate. This process should be communicated to parents and/or guardians at a minimum:

a. during the time of registration

b. each year during the first week of school

c. when a child is diagnosed and/or returns to school following a diagnosis;

3.5.2. Co-create, review or update the Plan of Care for a student with a prevalent medical condition with the parent(s) and/or guardians, in consultation with the school staff (as appropriate) and with the student (as appropriate).

3.5.3. Maintain a file with the Plan of Care and supporting documentation for each student with a prevalent medical condition.

3.5.4. Provide relevant information from the student's Plan of Care to school staff and others who are identified in the Plan of Care (e.g., food service providers, transportation providers, volunteers, occasional staff who will be in direct contact with the student), including any revisions that are made to the plan. Administrators are asked to include students' Plan of Care in a red folder entitled Emergency Plan of Care. This is to be posted in the students' classroom and common pertinent areas.

3.5.5. Communicate with parents and/or guardians in medical emergencies, as outlined in the Plan of Care.

3.5.6. Encourage the identification of staff who can support the daily or routine management needs of students in the school with prevalent medical conditions, while honoring the provisions within their collective agreements

3.6. Superior North Catholic District School Board

3.6.1. The Superior North Catholic School Board is expected to communicate, on an annual basis, its policies on supporting students with prevalent medical conditions to parents and/or guardians, school board staff, and others in the school community who are in direct contact with students (e.g. food service providers, transportation providers, volunteers). At a minimum, the Board is expected to make their policies and their Plan of Care templates available on their public website in the language of instruction.

3.6.2. In addition, the following are expected:

a. provide training and resources on prevalent medical conditions on an annual basis.

b. develop strategies that reduce the risk of student exposure to triggers or causative agents in classrooms and common school areas.

c. develop expectations for schools to support the safe storage and disposal of medication and medical supplies, and communicate these expectations to schools and support schools in the implementation of the expectations.

d. communicate expectations that students are allowed to carry their medication and supplies to support the management of their medical condition, as outlined in their Plan of Care.

e. consider PPM 161 and related board policies when entering into contracts with transportation, food service and other providers.

f. ensure at the time of registration there is a process for identifying students with prevalent medication conditions.

3.6.3. Where appropriate, the support and advice of community partners and health care providers should be sought for the purpose of ensuring the safety and well-being of students with a prevalent medical condition.

4.0. Communication Strategies/Privacy and Confidentiality

4.1. Due to the nature and severity of prevalent medical conditions, the school principal will establish a communication plan at the start of the school year to share information about students with prevalent medical conditions with parents and/or guardians, students, employees, volunteers, coaches, and where appropriate, food service providers, transportation providers and child care providers.

4.2. General communication about the prevalent medical conditions can be handled through board/school communication vehicles such as letters home to all parents, or through the school newsletter, board/school website, parent and/or guardian information nights and other school presentations.

4.3. The student's Plan of Care will identify those individuals in direct contact with the student during the course of their educational experience (including occasional teachers and volunteers) who will need training and/or information on the student's prevalent medical condition.

5.0. Responding to Medical Emergencies

5.1. The Board will determine and outline staff responses to medical incidents and/or medical emergencies at school that involve students with prevalent medical conditions which should align with existing school board medical emergency procedures (e.g. immediate response, including use of emergency medication and monitoring and/or calling Emergency).

6.0. Awareness Training/Resources

6.1. The Board will raise staff and student awareness of their policies on prevalent medical conditions. This should include triggers or causative agents, signs and symptoms of medical incidents and medical emergencies, and school board emergency procedures.

6.2. Schools, also, should raise awareness of prevalent medical conditions that affect students. They can do so, for example, through curriculum content in classroom, instruction, other related learning experiences, and classroom leadership opportunities. Awareness is especially important at times of transition (e.g. the move to a new school, the move from elementary to secondary school), when students have to face social, physiological and environmental changes.

7.0. Liability

7.1. The Good Samaritan Act, passed in 2001, protects individuals from liability with respect to voluntary emergency medical or first aid services. Subsections 2(1) and (2) of this act state the following with regard to individuals:

7.1.1. 2. (1) Despite the rules of common law, a person described in subsection (2) who voluntarily and without reasonable expectation of compensation or reward provides the services described in that subsection is not liable for damages that result from the person's negligence in acting or failing to act while providing the services, unless it is established that the damages were caused by the gross negligence of the person.

7.1.2. (2) Subsection (1) applies to,(b) an individual who provides emergency first aid to a person who is ill, injured or unconscious as a result of an accident or other emergency, if the individual provides the assistance at the immediate scene of the accident or emergency.

7.2. In addition, in the cases of anaphylaxis and asthma, both Sabrina's Law (2005) and Ryan's Law (2015) include provisions limiting the liability of individuals who respond to an emergency relating to these conditions, as cited below:

7.2.1. Section 3(4) of Sabrina's Law:

a. No action for damages shall be instituted respecting any act done in good faith or for any neglect or default in good faith in response to an anaphylactic reaction in accordance with this Act, unless the damages are the result of an employee's gross negligence.

7.2.2. Section 4(4) of Ryan's Law:

a. No action or other proceeding for damages shall be commenced against an employee for an act or omission done or omitted by the employee in good faith in the execution or intended execution of any duty or power under this Act.

PREVALENT MEDICAL CONDITION — ANAPHYLAXIS
Plan of Care

STUDENT INFORMATION

Student Name _____
Date Of Birth _____ _____ _____
Ontario Ed. # _____
Age _____
Grade _____
Teacher(s) _____

Student Photo (optional)

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

KNOWN LIFE-THREATENING TRIGGERS

CHECK (✓) THE APPROPRIATE BOXES

☐ Food(s): _____ ☐ Insect Stings: _____

☐ Other: _____

Epinephrine Auto-Injector(s) Expiry Date (s): _____ _____ _____

Dosage: ☐ EpiPen® Jr. 0.15 mg ☐ EpiPen® 0.30 mg

Location Of Auto-Injector(s): _____

☐ Previous anaphylactic reaction: **Student is at greater risk.**
☐ Has asthma. **Student is at greater risk.** If student is having a reaction and has difficulty breathing, give epinephrine before asthma medication.
☐ Any other medical condition or allergy?

_____

DAILY/ROUTINE ANAPHYLAXIS MANAGEMENT

SYMPTOMS

A STUDENT HAVING AN ANAPHYLACTIC REACTION MIGHT HAVE **ANY** OF THESE SIGNS AND SYMPTOMS:

- **Skin system:** hives, swelling (face, lips, tongue), itching, warmth, redness.
- Respiratory system (breathing): coughing, wheezing, shortness of breath, chest pain or tightness, throat tightness, hoarse voice, nasal congestion or hay fever-like symptoms (runny, itchy nose and watery eyes, sneezing), trouble swallowing.
- Gastrointestinal system (stomach): nausea, vomiting, diarrhea, pain or cramps.
- Cardiovascular system (heart): paler than normal skin colour/blue colour, weak pulse, passing out, dizziness or lightheadedness, shock.
- Other: anxiety, sense of doom (the feeling that something bad is about to happen), headache, uterine cramps, metallic taste.

EARLY RECOGNITION OF SYMPTOMS AND IMMEDIATE TREATMENT COULD SAVE A PERSON'S LIFE.

Avoidance of an allergen is the main way to prevent an allergic reaction.

Food Allergen(s): eating even a small amount of a certain food can cause a severe allergic reaction.

Food(s) to be avoided:

Safety measures:

Insect Stings: (Risk of insect stings is higher in warmer months. Avoid areas where stinging insects nest or congregate. Destroy or remove nests, cover or move trash cans, keep food indoors.)

Designated eating area inside school building:

Safety measures:

Other information:

EMERGENCY PROCEDURES
(DEALING WITH AN ANAPHYLACTIC REACTION)

ACT QUICKLY. THE FIRST SIGNS OF A REACTION CAN BE MILD, BUT SYMPTOMS CAN GET WORSE QUICKLY.

STEPS

1. Give epinephrine auto-injector (e.g. EpiPen®) at the first sign of a known or suspected anaphylactic reaction.

2. Call 9-1-1. Tell them someone is having a life-threatening allergic reaction.

3. Give a second dose of epinephrine as early as five (5) minutes after the first dose if there is no improvement in symptoms.

4. Follow direction of emergency personnel, including transport to hospital (ideally by ambulance), even if symptoms are mild or have stopped. The reaction could worsen or come back, even after treatment. Stay in the hospital for an appropriate period of observation as decided by the emergency department physician (generally about 4 - 6 hours).

5. Call emergency contact person; e.g. Parent(s)/Guardian(s).

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____ _____ _____

Special Instructions/Notes/Prescription Labels:

_____

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.
*This information may remain on file if there are no changes to the student's medical condition.

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Other individuals to be contacted regarding Plan Of Care:
Before-School Program ☐ Yes ☐ No _____
After-School Program ☐ Yes ☐ No _____
School Bus Driver/Route # (If Applicable) _____
Other: _____

This plan remains in effect for the _____ **–** _____ **school year without change and will be reviewed on or before:** _____**.** (It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year.)

Parent(s)/Guardian(s): _____ Date: _____ _____ _____

Student Signature: _____ Date: _____ _____ _____

Principal Signature: _____ Date: _____ _____ _____

PREVALENT MEDICAL CONDITION — EPILEPSY
Plan of Care

STUDENT INFORMATION

Student Name _____
Date Of Birth _____ _____ _____
Ontario Ed. # _____
Age _____
Grade _____
Teacher(s) _____

Student Photo (optional)

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

Has an emergency rescue medication been prescribed? ☐ Yes ☐ No

If yes, attach the rescue medication plan, healthcare providers' orders and authorization from the student's parent(s)/guardian(s) for a trained person to administer the medication.

Note: Rescue medication training for the prescribed rescue medication and route of administration (e.g. buccal or intranasal) must be done in collaboration with a regulated healthcare professional.

KNOWN LIFE-THREATENING TRIGGERS

CHECK (✓) THE APPROPRIATE BOXES

☐ Stress ☐ Menstrual Cycle ☐ Inactivity

☐ Changes ☐ In Diet ☐ Lack Of Sleep Electronic Stimulation (TV, Videos, Fluorescent Lights)

☐ Illness ☐ Improper Medication Balance

☐ Change In Weather ☐ Other _____

☐ Any Other Medical Condition or Allergy? _____

DAILY/ROUTINE EPILEPSY MANAGEMENT

DESCRIPTION OF SEIZURE (NON-CONVULSIVE)	ACTION: (e.g. description of dietary therapy, risks to be mitigated, trigger avoidance.)
DESCRIPTION OF SEIZURE (CONVULSIVE)	**ACTION:**

SEIZURE MANAGEMENT

Note: It is possible for a student to have more than one seizure type.
Record information for each seizure type.

SEIZURE TYPE	ACTIONS TO TAKE DURING SEIZURE
(e.g. tonic-clonic, absence, simple partial, complex partial, atonic, myoclonic, infantile spasms) Type: Description:	

Frequency of seizure activity: _____

Typical seizure duration: _____

BASIC FIRST AID: CARE AND COMFORT

First aid procedure(s):

Does student need to leave classroom after a seizure? ☐ Yes ☐ No

If yes, describe process for returning student to classroom:

BASIC SEIZURE FIRST AID

- Stay calm and track time and duration of seizure
- Keep student safe
- Do not restrain or interfere with student's movements
- Do not put anything in student's mouth
- Stay with student until fully conscious

FOR TONIC-CLONIC SEIZURE:

- Protect student's head
- Keep airway open/watch breathing
- Turn student on side

EMERGENCY PROCEDURES

Students with epilepsy will typically experience seizures as a result of their medical condition.

Call 9-1-1 when:

- Convulsive (tonic-clonic) seizure lasts longer than five (5) minutes.
- Student has repeated seizures without regaining consciousness.
- Student is injured or has diabetes.
- Student has a first-time seizure.
- Student has breathing difficulties.
- Student has a seizure in water

*Notify parent(s)/guardian(s) or emergency contact.

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____ _____ _____

Special Instructions/Notes/Prescription Labels:

_____

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.
*This information may remain on file if there are no changes to the student's medical condition.

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Other individuals to be contacted regarding Plan Of Care:
Before-School Program ☐ Yes ☐ No _____
After-School Program ☐ Yes ☐ No _____
School Bus Driver/Route # (If Applicable) _____
Other: _____

This plan remains in effect for the _____ – _____ school year without change and will be reviewed on or before: _____. (It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year.)

Parent(s)/Guardian(s): _____ Date: _____ _____ _____

Student Signature: _____ Date: _____ _____ _____

Principal Signature: _____ Date: _____ _____ _____

PREVALENT MEDICAL CONDITION — ASTHMA
Plan of Care

STUDENT INFORMATION

Student Name _____
Date Of Birth _____ _____ _____
Ontario Ed. # _____
Age _____
Grade _____
Teacher(s) _____

Student Photo (optional)

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

Has an emergency rescue medication been prescribed? ☐ Yes ☐ No

If yes, attach the rescue medication plan, healthcare providers' orders and authorization from the student's parent(s)/guardian(s) for a trained person to administer the medication.

Note: Rescue medication training for the prescribed rescue medication and route of administration (e.g. buccal or intranasal) must be done in collaboration with a regulated healthcare professional.

KNOWN LIFE-THREATENING TRIGGERS

CHECK (✓) THE APPROPRIATE BOXES

☐ Colds/Flu/Illness ☐ Change In Weather ☐ Pet Dander ☐ Strong Smells
☐ Smoke (e.g., tobacco, fire, cannabis, second-hand smoke)
☐ Mould ☐ Dust ☐ Cold Weather ☐ Pollen ☐ Physical Activity/Exercise
☐ Other (Specify) _____
☐ At Risk For Anaphylaxis (Specify Allergen) _____
☐ Asthma Trigger Avoidance Instructions: _____
☐ Any Other Medical Condition Or Allergy?

_____

DAILY/ ROUTINE ASTHMA MANAGEMENT

RELIEVER INHALER USE AT SCHOOL AND DURING SCHOOL-RELATED ACTIVITIES

A reliever inhaler is a fast-acting medication (usually blue in colour) that is used when someone is having asthma symptoms. The reliever inhaler should be used:

☐ When student is experiencing asthma symptoms (e.g., trouble breathing, coughing, wheezing).

☐ Other (explain): _____

Use reliever inhaler _____ in the dose of _____
(Name of Medication) (Number of Puffs)

Spacer (valved holding chamber) provided? ☐ Yes ☐ No

Place a (✓) check mark beside the type of reliever inhaler that the student uses:
☐ Airomir ☐ Ventolin ☐ Bricanyl ☐ Other (Specify) _____
☐ Student requires assistance to **access** reliever inhaler. Inhaler must be **readily accessible**.

Reliever inhaler is kept:
☐ With _____ – location: _____ Other Location: _____
☐ In locker # _____ Locker Combination: _____
☐ Student **will carry** their reliever inhaler **at all times** including during recess, gym, outdoor and off-site activities.

Reliever inhaler is kept in the student's:
☐ Pocket ☐ Backpack/fanny Pack ☐ Case/pouch ☐ Other (specify): _____

Does student require assistance to **administer** reliever inhaler? ☐ Yes ☐ No
☐ Student's **spare** reliever inhaler is kept:
☐ In main office (specify location): _____ Other Location: _____
☐ In locker # _____ Locker Combination: _____

CONTROLLER MEDICATION USE AT SCHOOL AND DURING SCHOOL-RELATED ACTIVITES

Controller medications are taken regularly every day to control asthma. Usually, they are taken in the morning and at night, so generally not taken at school (unless the student will be participating in an overnight activity).

Use/administer _____ In the dose of _____ At the following times: _____
(Name of Medication)

Use/administer _____ In the dose of _____ At the following times: _____
(Name of Medication)

Use/administer _____ In the dose of _____ At the following times: _____
(Name of Medication)

EMERGENCY PROCEDURES

IF ANY OF THE FOLLOWING OCCUR:

- Continuous coughing
- Trouble breathing
- Chest tightness
- Wheezing (whistling sound in chest)

(* Student may also be restless, irritable and/or quiet.)

TAKE ACTION:

STEP 1: Immediately use fast-acting reliever inhaler (usually a blue inhaler). Use a spacer if provided.

STEP 2: Check symptoms. Only return to normal activity when all symptoms are gone. If symptoms get worse or do not improve within 10 minutes, this is an **EMERGENCY!**
Follow steps below.

IF ANY OF THE FOLLOWING OCCUR:

- Breathing is difficult and fast
- Cannot speak in full sentences
- Lips or nail beds are blue or grey
- Skin or neck or chest sucked in with each breath

(*Student may also be anxious, restless, and/or quiet.)

THIS IS AN EMERGENCY:

STEP 1: **IMMEDIATELY USE ANY FAST-ACTING RELIEVER (USUALLY A BLUE INHALER). USE A SPACER IF PROVIDED.**
Call 9-1-1 for an ambulance.
Follow 9-1-1 communication protocol with emergency responders.

STEP 2: If symptoms continue, use reliever inhaler every 5-15 minutes until medical attention arrives.

While waiting for medical help to arrive:

- ✓ Have student sit up with arms resting on a table (do not have student lie down unless it is an anaphylactic reaction).
- ✓ Do not have the student breathe into a bag.
- ✓ Stay calm, reassure the student and stay by his/her side.
- ✓ Notify parent(s)/guardian(s) or emergency contact.

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____ _____ _____

Special Instructions/Notes/Prescription Labels:

_____

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.
*This information may remain on file if there are no changes to the student's medical condition.

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Other individuals to be contacted regarding Plan Of Care:
Before-School Program ☐ Yes ☐ No _____
After-School Program ☐ Yes ☐ No _____
School Bus Driver/Route # (If Applicable) _____
Other: _____

This plan remains in effect for the _____ – _____ school year without change and will be reviewed on or before: _____. (It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year.)

Parent(s)/Guardian(s): _____ Date: _____ _____ _____

Student Signature: _____ Date: _____ _____ _____

Principal Signature: _____ Date: _____ _____ _____

PREVALENT MEDICAL CONDITION — TYPE 1 DIABETES
Plan of Care

STUDENT INFORMATION

Student Name
Date Of Birth _____ _____ _____
Ontario Ed. #
Age
Grade
Teacher(s)

Student Photo (optional)

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

TYPE 1 DIABETES SUPPORTS

Names of trained individuals who will provide support with diabetes-related tasks: (e.g. designated staff or community care allies.)

Method of home-school communication:

Any other medical condition or allergy?

DAILY/ROUTINE TYPE 1 DIABETES MANAGEMENT

Student is able to manage their diabetes care independently and does not require any special care from the school.

☐ Yes ☐ No

☐ If Yes, go directly to page five (5) — Emergency Procedures

ROUTINE	ACTION
BLOOD GLUCOSE MONITORING ☐ Student requires trained individual to check BG/ read meter. ☐ Student needs supervision to check BG/ read meter. ☐ Student can independently check BG/ read meter. ☐ Student has continuous glucose monitor (CGM) * Students should be able to check blood glucose anytime, anyplace, respecting their preference for privacy.	Target Blood Glucose Range Time(s) to check BG: Contact Parent(s)/Guardian(s) if BG is: Parent(s)/Guardian(s) Responsibilities: School Responsibilities: Student Responsibilities:
NUTRITION BREAKS ☐ Student requires supervision during meal times to ensure completion. ☐ Student can independently manage his/her food intake. * Reasonable accommodation must be made to allow student to eat all of the provided meals and snacks on time. Students should not trade or share food/ snacks with other students.	Recommended time(s) for meals/snacks: Parent(s)/Guardian(s) Responsibilities: School Responsibilities: Student Responsibilities: Special instructions for meal days/ special events:

ROUTINE	ACTION (CONTINUED)
INSULIN ☐ Student does not take insulin at school. ☐ Student takes insulin at school by: ☐ Injection ☐ Pump ☐ Insulin is given by: ☐ Student ☐ Student with supervision ☐ Parent(s)/Guardian(s) ☐ Trained Individual * All students with Type 1 diabetes use insulin. Some students will require insulin during the school day, typically before meal/nutrition breaks.	Location of insulin: Required times for insulin: ☐ Before school: ☐ Morning Break: ☐ Lunch Break: ☐ Afternoon Break: ☐ Other (Specify): _____ Parent(s)/Guardian(s) Responsibilities: School Responsibilities: Student Responsibilities: Additional Comments:
ACTIVITY PLAN Physical activity lowers blood glucose. BG is often checked before activity. Carbohydrates may need to be eaten before/ after physical activity. A source of fast-acting sugar must always be within students' reach.	Please indicate what this student must do prior to physical activity to help prevent low blood sugar. 1.Before activity: _____ 2.During activity: _____ 3.After activity: _____ Parent(s)/Guardian(s) Responsibilities: School Responsibilities: Student Responsibilities: For special events, notify parent(s)/guardian(s) in advance so that appropriate adjustments or arrangements can be made. (e.g. extracurricular, Terry Fox Run)

ROUTINE	ACTION (CONTINUED)
DIABETES MANAGEMENT KIT Parents must provide, maintain, and refresh supplies. School must ensure this kit is accessible all times. (e.g. field trips, fire drills, lockdowns) and advise parents when supplies are low.	Kits will be available in different locations but will include: ☐ Blood Glucose meter, BG test strips, and lancets ☐ Insulin and insulin pen and supplies. ☐ Source of fast-acting sugar (e.g. juice, candy, glucose tabs.) ☐ Carbohydrate containing snacks ☐ Other (Please list) Location of Kit:
SPECIAL NEEDS A student with special considerations may require more assistance than outlined in this plan.	Comments:

EMERGENCY PROCEDURES

HYPOGLYCEMIA – LOW BLOOD GLUCOSE (4 mmol/L or less) DO NOT LEAVE STUDENT UNATTENDED

Usual symptoms of Hypoglycemia for my child are:

☐ Shaky	☐ Irritable/Grouchy	☐ Dizzy	☐ Trembling
☐ Blurred Vision	☐ Headache	☐ Hungry	☐ Weak/Fatigue
☐ Pale	☐ Confused	☐ Other _____	

Steps to take for **Mild** Hypoglycemia (student is responsive)

1. Check blood glucose, give _____ grams of fast acting carbohydrate (e.g. ½ cup of juice, 15 skittles)
2. Re-check blood glucose in 15 minutes.
3. If still below 4 mmol/L, repeat steps 1 and 2 until BG is above 4 mmol/L. Give a starchy snack if next meal/snack is more than one (1) hour away.

Steps for **Severe** Hypoglycemia (student is unresponsive)

1. Place the student on their side in the recovery position.
2. Call 9-1-1. Do not give food or drink (choking hazard). Supervise student until emergency medical personnel arrives.
3. Contact parent(s)/guardian(s) or emergency contact

HYPERGLYCEMIA — HIGH BLOOD GLOCOSE (14 mmol/L OR ABOVE)

Usual symptoms of hyperglycemia for my child are:

☐ Extreme Thirst	☐ Frequent Urination	☐ Headache
☐ Hungry	☐ Abdominal Pain	☐ Blurred Vision
☐ Warm, Flushed Skin	☐ Irritability	☐ Other: _____

Steps to take for **Mild** Hyperglycemia

1. Allow student free use of bathroom
2. Encourage student to drink water only
3. Inform the parent/guardian if BG is above _____

Symptoms of Severe Hyperglycemia (Notify parent(s)/guardian(s) immediately)

☐ Rapid, Shallow Breathing	☐ Vomiting	☐ Fruity Breath

Steps to take for **Severe** Hyperglycemia

1. If possible, confirm hyperglycemia by testing blood glucose
2. Call parent(s)/guardian(s) or emergency contact

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____ _____ _____

Special Instructions/Notes/Prescription Labels:

_____

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.
*This information may remain on file if there are no changes to the student's medical condition.

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Other individuals to be contacted regarding Plan Of Care:
Before-School Program ☐ Yes ☐ No _____
After-School Program ☐ Yes ☐ No _____
School Bus Driver/Route # (If Applicable) _____
Other: _____

This plan remains in effect for the _____ – _____ school year without change and will be reviewed on or before: _____. (It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year.)

Parent(s)/Guardian(s): _____ Date: _____ _____ _____

Student Signature: _____ Date: _____ _____ _____

Principal Signature: _____ Date: _____ _____ _____

PREVALENT MEDICAL CONDITION
Plan of Care

STUDENT INFORMATION

Student Name _____
Date Of Birth _____ _____ _____
Ontario Ed. # _____
Age _____
Grade _____
Teacher(s) _____

Student Photo (optional)

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

Has an emergency rescue medication been prescribed? ☐ Yes ☐ No

If yes, attach the rescue medication plan, healthcare providers' orders and authorization from the student's parent(s)/guardian(s) for a trained person to administer the medication.

Note: Rescue medication training for the prescribed rescue medication and route of administration (e.g. buccal or intranasal) must be done in collaboration with a regulated healthcare professional.

KNOWN TRIGGERS AND/OR SYMPTOMS

☐ Vision Loss
☐ Cerebral palsy
☐ Hearing Loss
☐ Organ damage
☐ Tourette syndrome
☐ Cancer
☐ Spinal Cord Injury
☐ Cystic fibrosis
☐ Narcolepsy
☐ Arthritis
☐ Irritable Bowel Syndrome
☐ Glaucoma
☐ Spina Bifida
☐ Multiple sclerosis
☐ Brain injury
☐ Muscular dystrophy
☐ Heart condition

☐ Other _____

☐ Any Other Medical Condition or Allergy? _____

DAILY/ROUTINE MANAGEMENT

DESCRIPTION OF SYMPTOMS	ACTION:

BASIC FIRST AID: CARE AND COMFORT

First aid procedure(s):

Does student need to leave classroom after a seizure? ☐ Yes ☐ No

If yes, describe process for returning student to classroom:

BASIC FIRST AID

-
-
-
-
-
-
-

EMERGENCY PROCEDURES

* Notify parent(s)/guardian(s) or emergency contact.

Call 9-1-1 when:

-
-
-
-
-
-
-

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____ _____ _____

Special Instructions/Notes/Prescription Labels:

_____

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.
*This information may remain on file if there are no changes to the student's medical condition.

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Other individuals to be contacted regarding Plan Of Care:
Before-School Program ☐ Yes ☐ No _____
After-School Program ☐ Yes ☐ No _____
School Bus Driver/Route # (If Applicable) _____
Other: _____

This plan remains in effect for the _____ – _____ school year without change and will be reviewed on or before: _____. (It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year.)

Parent(s)/Guardian(s): _____ Date: _____ _____ _____

Student Signature: _____ Date: _____ _____ _____

Principal Signature: _____ Date: _____ _____ _____

ADMINISTRATION OF MEDICATION PARENT CONSENT FORM.

It is understood that it is preferable that all medication be administered by the parent/guardian at home during non-school hours. The parent or guardian should ask the student's physician if the medication must be administered during school hours and/or if an alternative medication could be prescribed that does not require administration during school hours.

TO BE COMPLETED BY PARENT/GUARDIAN:

Name of Student: _____ ***Birth Date:*** _____ _____ _____

School: _____ ***Grade:*** _____

Home Address: _____

_____

_____

Phone # of Parent/Guardian: _____ ***(Home)*** _____ ***(Work)***

Name of Dispensing Pharmacy: _____

Address: _____ ***Phone:*** _____

_____

Name of Physician: _____

Address: _____ ***Phone:*** _____

_____

1.1. As the parent/guardian of the above-named student, I request and authorize the oral administration to said student of the prescribed medication referred to below, using the procedures outlined below, by school personnel, who I acknowledge are not medically trained to administer medication.

1.2. I understand that no more than one month's dosage is to be sent to the school at any one time.

1.3. I understand and accept that if questions arise about administering the medication, the school principal, or his/her designate, will contact the dispensing pharmacy to clarify the issue; for example, (including without limitation) whether there is a need to give the medication on an empty or full stomach.

1.4. I also understand and accept that if problems arise with the administration of the medication; for example, (including without limitation) refusal by the student to take the medication, complaints of side effects, or possible allergic reactions, then the school will immediately discontinue further doses and inform the parent or guardian, at the earliest practical opportunity, as to the nature of the problem. It is then the parents'/guardians' responsibility to decide if the student's physician needs to be consulted to assess whether changes to the prescribed medication and/or administrative procedures referred to below are necessary. A new copy of this medication form must be completed for any change in the medication prescribed and/or the administrative procedure referred to below.

1.5. I also understand and accept that the school principal can reserve the right to refuse to administer treatment to the student if the necessary information is not provided by the parent/guardian.

1.6. I confirm that I have asked the student's physician if the medication must be administered during school hours and he/she has so advised.

1.7. The information gathered in this form is collected pursuant to the Education Act and the Municipal Freedom of Information and Protection of Privacy Act.

1.8. The information will be used to assist with meeting the health needs of the student.

1.9. If there are any questions about the information gathered on this form, please contact the principal of the student's school.

1.10. This request will terminate on June 30th of each school year.

1.11. I hereby release the School Board, its employees and agents from all manner of actions, causes of action, suits, losses, damages or injuries, however caused, arising out of the administration or failure to administer medication as provided herein, and I do also hereby indemnify the said School Board, its employees or agents, for any losses or damages sustained by them as a result of such actions or proceedings being commenced against them by myself or the student or any other parent or guardian of said student.

1.12. I hereby acknowledge that I have read and fully understand the terms set out herein.

1.13. I am satisfied with the training that I have given the person who will administer medication to my child.

MEDICATION INFORMATION: TO BE FILLED IN BY PARENT/GUARDIAN

Diagnosis/Reason for Medication: _____

_____

Medication(s) Prescribed	Dosage	Time of Administration
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

Possible Side Effects (If Any): _____

Duration of Continuing Medication(s): _____

Parent/Guardian Signature:

Date: _____