Protocols for Prevalent Medical Conditions

Appendices & Forms

Toronto Catholic District School Board

School Based Student Support Services

EMERGENCY ALLERGY FORM

EPI-PEN ONLY

Name: _____

Address:

_____

Home Phone: _____

Emergency Phone _____

Parent/Guardian Work Phone: _____

Parent/Guardian Work Phone: _____

Teacher: _____

Class: _____ Room # _____

Health Card #: _____

Physician _____

Physician's Telephone _____

Allergy-Description: This child has a **DANGEROUS,** life threatening allergy to the following items and to all foods containing them in any form in any amount:

Avoidance: The key to preventing an emergency is **Absolute Avoidance** of those foods at all times

Without An EPI-PEN This Child Must Not Be Allowed to EAT Anything.

Eating Rules: *(list eating rules for child, if any, in this space)*

Possible Symptions:

- ☐ Flushed face, hives, swelling or itchy lips, tongue, eyes
- ☐ tightness in throat, mouth, chest
- ☐ Difficulty breathing or swallowing, wheezing, coughing, choking pains
- ☐ Vomiting, nausea, diarrhea, stomach pain
- ☐ Dizziness, unsteadiness, sudden fatigue, rapid heartbeat
- ☐ Loss of consciousness

Action - Emergency Plan: At any sign of difficulty(e.g. hives, swelling, difficulting breathing);

- ☐ Use EPI-PEN immediately
- ☐ Have Someone Call An Ambulance to advise the dispatcher that the child is having an anaphylactic reaction.
- ☐ If ambulance has not arrived in 15-20 minutes and symptoms reappear or become worse, give a second EPI-P
- ☐ Even if symptoms subside entirely, this child must be taken to a hospital immediately.

Distribution: Original: OSR

EPI-PENS are kept in _____ *Classroom/lunchroom/staff room/office/with student*

Toronto Catholic District School Board

REQUEST AND CONSENT FOR THE ADMINISTRATION OF ORAL MEDICATION

Student Name _____ _____ Student No. _____
SURNAME FIRSTNAME

Birthdate _____ Grade/Placement _____ School _____
YYYY/MM/DD

SCHOOL ADDRESS _____

I/WE, THE PARENT(S)/GUARDIAN REQUEST AND CONSENT FOR THE ADMINISTRATION OF ORAL MEDICATION.

Home Tel. _____ Home Tel. _____

I/We _____ Bus. Tel. _____ Bus. Tel. _____

request that the TCDSB provide for the administration of medication for my /our son/daughter.

I/We understand that:

a) a medical doctor must consent to this request in accordance with Section 2 of this form.

b) only a limited supply of the medication may be kept at the school as prescribed by the doctor;

c) the medication must be brought to the school in a closed container and the label must detail the name of the student, the type/name of the medication, and the size of the dosage;

d) if the medication is not provided to the school, contact will be made with the parent(s)/guardian or doctor, and will also be made with parent(s)/guardian or doctor under any other exceptional circumstances, e.g. pupil refuses medication;

e) it is the responsibility of the school to establish fall back positions for the administration of oral medication.

I/We consent to:

a) the establishment of a service at the school to administer prescribed medication to my/our son/daughter named above;

b) school personnel responsible for the administration of medication discussing any aspect of the service with a public health nurse where the need arises.

_____ _____ _____
Date Y-M-D Signature of Parent/Guardian Signature of Parent/Guardian

Please have the family doctor complete Part 2 on reverse side of this form.

Distribution: Original: OSR Copy: Parent(s)/Guardian, Special Program Files(s)

Toronto Catholic District School Board

REQUEST AND CONSENT FOR THE ADMINISTRATION OF ORAL MEDICATION

Student Name _____ _____ Student No. _____
SURNAME FIRSTNAME

II. DOCTOR'S APPROVAL FOR THE ADMINISTRATION OF ORAL MEDICATION IN THE SCHOOL

1. Diagnosis:

2.

Medication Prescribed	Dosage	Time of Administration			Amount to be Maintained at School
		Mid - AM	Noon	Mid - PM	
a)					
b)					

3. The parent(s)/guardian of the above named pupil have requested the Toronto Catholic District School Board to offer a service for the administration of medication to their child in the school. The Board requires a doctor's approval before implementing such a program. Your signature below will provide required approval with the following specific directions (if any, e.g. refrigeration, reactions):

I approve the administration of oral medication as described above for:

_____
Student's Name

_____
Doctor's Signature

_____
Date: Y-M-D

PLEASE USE DOCTOR'S STAMP

III. TCDSB STAFF APPROVAL FOR IMPLEMENTION

The administration of oral medication service will be implemented as of:

_____ _____ _____
Date Y-M-D Principal's Signature Signature of Parent/Guardian

Personal information contained on this form is collected under the authority of Sections 8 and 11 of the Education Act, and will be used as an authorization for prescribed medication. Questions about this collection should be directed to the above doctor through the parent(s)/guardian.

Distribution: Original: OSR Copy: Parent(s)/Guardian, Special Program Files(s)

Toronto Catholic District School Board

REQUEST AND CONSENT FOR THE ADMINISTRATION OF INJECTION OF MEDICATION IN AN EMERGENCY

Student Name _____ _____ Student No. _____
SURNAME FIRSTNAME

Birthdate _____ Grade/Placement _____ School _____
YYYY/MM/DD

I. THE PARENT(S)/GUARDIAN REQUEST AND CONSENT FOR THE ADMINISTRATION OF AN INJECTION OF MEDICATION IN AN EMERGENCY IN THE SCHOOL.

Home Tel. _____ Home Tel. _____

Bus. Tel _____ Bus. Tel. _____

I/We request that the TCDSB provide for the administration of an emergency injection of medication for my /our son/daughter in the event that the following should happen:

_____

I/We understand that:

a) a medical doctor must consent to this request in accordance with Section 2 of this form.

b) only a limited supply of the medication may be kept at the school as prescribed by the doctor;

c) the medication must be brought to the school in a closed container and the label must detail the name of the student, the type/name of the medication, and the size of the dosage;

d) if the medication is not provided to the school, contact will be made with the parent(s)/guardian or doctor, and will also be made with parent(s)/guardian or doctor under any other exceptional circumstances, e.g. pupil refuses medication

e) it is the responsibility of the school to establish fall back positions for the administration of emergency medication

I/We consent to:

a) the establishment of a service at the school to administer an emergency injection of medication to my/our son/daughter named above in the event of an emergency situation as outlined above;

b) school personnel responsible for the administration of medication in an emergency situation discussing any aspect of the service with a public health nurse where the need arises.

_____ _____ _____
Date Y-M-D Signature of Parent/Guardian Signature of Parent/Guardian

Personal information contained on this form is collected under the authority of Section 8 and 11 of the Education Act, and will be used as an authorization for prescribed medication. Question about this collection should be directed to the parent(s)/guardian.

Please have the family doctor complete Part 2 on reverse side of this form.

Distribution: Original: OSR Copy: Parent(s)/Guardian, Special Program Files(s) (if applicable)

Toronto Catholic District School Board

REQUEST AND CONSENT FOR THE ADMINISTRATION OF INJECTION OF MEDICATION IN AN EMERGENCY

Student Name _____ _____ Student No. _____
SURNAME FIRSTNAME

II. DOCTOR'S APPROVAL FOR THE ADMINISTRATION OF MEDICATION IN THE SCHOOL

1. Diagnosis:

2. Reason for injection:

3. When should the injection of medication be administered?

4. Where should the injection be administered?

5. Additional directions

Medication Prescribed	Dosage	Amount to be Maintained at School
a)		
b)		

6. The parent(s)/guardian of the above named pupil have requested the Toronto Catholic District School Board to offer a service for the administration of an injection of medication in an emergency to their child in the school. The Board requires a doctor's approval before implementing such a program. Your signature below will provide required approval with the following specific directions (if any, e.g. refrigeration, reactions):

I approve the administration of an injection of medication in an emergency as described above for:

_____
Student's Name

_____
Doctor's Signature

_____
Date: Y-M-D

PLEASE USE DOCTOR'S STAMP

III. TCDSB STAFF APPROVAL FOR IMPLEMENTION

The administration of an injection of medication in an emergency will be implemented as described above. At the same time, school personnel will contact emergency ambulance services.

_____ _____
Date Y-M-D Principal's Signature

Personal information contained on this form is collected under the authority of Sections 8 and 11 of the Education Act, and will be used as an authorization for prescribed medication. Questions about this collection should be directed to the above doctor through the parent(s)/guardian.

Distribution: Original: OSR Copy: Parent(s)/Guardian, Special Program Files(s) (if applicable)

Toronto Catholic District School Board

SCHOOL RECORD OF MEDICAL SERVICES

Student Name: _____ _____ Student No. _____
SURNAME FIRSTNAME

Birthdate: _____ Grade/Placement: ____ School: _____
YYYY/MM/DD

SERVICE PROVIDED	DATE Year/Month/Day	TIME	INITIALS OF PERSON PROVIDING SERVICE

Distribution: Original: OSR Copy: Special Program Files(s) (if applicable)

TORONTO CATHOLIC DISTRICT SCHOOL BOARD

East

Consent to Disclose Personal Health Information

Pursuant to the personal Health Information Protection Act, 2004 (PHIPA)

I, _____ , authorize _____

(print full name of person) *(print name of health information custodian)*

to disclose

☑ my personal health information consisting of:

_____

(Describe the personal health information to be disclosed)

or

☑ the personal health information of _____

(Name of person for whom you are the substitute decision-maker*)

consisting of:

_____

(Describe the personal health information to be disclosed)

to _____

(Print name and address of person requiring the information)

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form.

My Name:		**Address:**	
Home Tel:		**Work Tel:**	
Signature:		**Date:**	
My Name:		**Address:**	
Home Tel:		**Work Tel:**	
Signature:		**Date:**	

***Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**

7530-4979

6434-41(00/12)*

Student Plan of Care for ANAPHYLAXIS

School Year: 20__- 20-__

Student Name	**Date of Birth**	**Gender**	**Student Photo**
Address		**Student #**	
Exceptionality	**Teacher(s)**	**Medic Alert I.D.**	
	_____		
	_____	**Yes ☐ No ☐**	
	_____		
	_____		
Grade	**Age**	**OEN #**	

EMERGENCY CONTACT (LIST IN PRIORITY)			
NAME:	RELATIONSHIP	MAIN CONTACT #	ALTERNATE #
1.			
2.			
3.			
4.			

(HAVE ABILITY TO ADD MORE CONTACTS)

SUPPORTS FOR ANAPHYLAXIS

Name of trained individuals who will provide support with Anaphylaxis-related tasks:
Designated Staff:_____
Local Health Integration Network (LHIN) Care Workers (if applicable):
_____
Method of home-school communication:_____
Any other medical condition or allergy? ☐ No ☐ Yes (Please list below)

1. _____
2. _____
3. _____

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 light-headedness, 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 or local emergency medical services. 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. Go to the nearest hospital immediately (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).

EXCURSION PROTOCOL

Please refer to the Excursion Handbook when planning for excursions and ensure that accommodations are made for the student with Anaphylaxis:
https://www.tcdsb.org/ProgramsServices/SchoolProgramsK12/HealthOutdoorPhysEd/ExcursionHandbook/Documents/Excursion-Handbook-updated-Nov-30-2015.pdf

During all trips off school property, the parent/guardian will provide an excursion kit which will consist of:

- ☐ Epi-pens (refer to Excursion Handbook for further information)
- ☐ Emergency Contact
- ☐ Cell phone (if parent/guardian chooses)

HEALTHCARE PROVIDER INFORMATION (MANDATORY)

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 Instruction/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 medication **cannot** be beyond the expiration date. 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 20___ - 20___ 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 and to inform the school of any change of medication or delivery device during the school year.

Consent to treatment: I am aware that school staff are not medical professionals and perform all aspects of the plan to the best of their abilities and in good faith.

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

Student: _____ Date: _____
(signature for student 16 years of age or older)

Principal: _____ Date: _____
(signature)

Student Plan of Care for ASTHMA

School Year: 20__-20__

Student Name	**Date of Birth**	**Gender**	**Student Photo**
Address		**Student #**	
Exceptionality	**Teacher(s)** _____	**Medic Alert I.D.** **Yes ☐ No ☐**	
	_____		
Grade	**Age**	**OEN #**	

EMERGENCY CONTACT (LIST IN PRIORITY)			
NAME:	RELATIONSHIP	MAIN CONTACT #	ALTERNATE #
1.			
2.			
3.			
4.			

(HAVE ABILITY TO ADD MORE CONTACTS)

SUPPORTS FOR ASTHMA

Name of trained individuals who will provide support with asthma-related tasks:
Designated Staff:_____

Local Health Integration Network (LHIN) Care Workers (if applicable):
_____

Method of home-school communication:_____
Any other medical condition or allergy? ☐ No ☐ Yes (Please list below)

1. _____
2. _____
3. _____

Known Asthma Triggers
Check all those that apply

☐ colds/flu/illness ☐ change in weather ☐ pet dander ☐ strong smells
☐ smoke (i.e. tobacco, fire, cannabis, second-hand smoke)
☐ mould ☐ dust ☐ pollen ☐ cold weather
☐ physical activity/exercise
☐ allergies (specify): _____
☐ at risk for anaphylaxis (specify allergen):
_____
☐ asthma trigger avoidance instructions:
_____

Use of Reliever Medication and Controller Medication at school and during out of school activities

A. ☐ student **will carry and/or self-administer** reliever/controller medication in all settings as prescribed.
Reliever/controller medication is kept:
☐ pocket/person ☐ backpack/fanny pack ☐ case/pouch
☐ other: (specify) _____

B. ☐ student **requires assistance to administer** reliever/controller medication in all settings as prescribed.
Please explain: _____
_____
_____
☐ back-up reliever inhaler is available and will be kept in the main office

The supervising teachers will have back up reliever inhaler during sporting events, excursions, and all other out of school activities to be used in emergency situations.
Each time staff administer prescribed asthma medication information must be recorded on the: Student Log of Administered Medication form.

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 (i.e. trouble breathing, coughing, wheezing).
☐ other (explain): _____
Use of reliever inhaler _____ in the dose of _____
(Name of Medication) (# of puffs)

Spacer (valved holding chamber) provided ☐ Yes ☐ No
Place a check mark beside the type of **reliever inhaler** that the student uses:
☐ salbutamol ☐ airomir ☐ ventolin ☐ bricanyl
☐ other (specify): _____

Controller Medication use at school and during school related activities

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 student will be participating in an overnight activity). Place a check mark beside the type of prescribed **controller medication** that the student uses:
☐ flovent ☐ advair ☐ qvar ☐ pulmicort
☐ other (specify): _____

Use/administer _____ in the dose of _____ at the following time(s): _____
(Name of Medication)

Use/administer _____ in the dose of _____ at the following time(s): _____
(Name of Medication)

Use/administer _____ in the dose of _____ at the following time(s): _____
(Name of Medication)

EMERGENCY PROCEDURES DURING ASTHMA ATTACK

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 persist, do not improve within 10 minutes or get worse, this is an **EMERGENCY!** Follow the 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

Consent for student to carry and self-administer asthma medication

We agree that _____,
(student name)

☐ can **carry** prescribed medications and delivery devices to manage asthma while at school and during school-related activities.

☐ can **self-administer** prescribed medications and delivery devices to manage asthma while at school and during school-related activities.

☐ **requires assistance** with administering prescribed medications and delivery devices to manage asthma while at school and during school-related activities.

Parent/Guardian Name: _____ Signature: _____ Date: _____

Parent/Guardian Name: _____ Signature: _____ Date: _____

Student Name: _____ Signature: _____ Date: _____

Principal Name: _____ Signature: _____ Date: _____

EXCURSION PROTOCOL

Please refer to the Excursion Handbook when planning for excursions and ensure that accommodations are made for the student with Asthma:
https://www.tcdsb.org/ProgramsServices/SchoolProgramsK12/HealthOutdoorPhysEd/ExcursionHandbook/Documents/Excursion-Handbook-updated-Nov-30-2015.pdf

During all trips off school property, the parent/guardian will provide an excursion kit which will consist of:

☐ Inhalers (refer to Excursion Handbook for further information)
☐ Emergency Contact
☐ Cell phone (if parent/guardian chooses)

HEALTHCARE PROVIDER INFORMATION (MANDATORY)

To be included by healthcare professional (I.E.: Pharmacist, Respiratory Therapist, Certified Asthma Educator, Certified Respiratory Educator, Nurse, Medical Doctor or other clinician working within their scope of practice)

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____

Special Instructions/Notes/Prescription Labels/Comments:

_____

_____

_____

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 medication **cannot** be beyond the expiration date.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 20___- 20___ 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 and to inform the school of any change of medication or delivery device during the school year.

Consent to treatment: I am aware that school staff are not medical professionals and perform all aspects of the plan to the best of their abilities and in good faith.

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

Student: _____ Date: _____
(signature for student 16 years of age or older)

Principal: _____ Date: _____
(signature)

Student Plan of Care for

DIABETES

School Year: 20__- 20__

Student Name	Date of Birth	Gender	Student Photo
Address		Student #	
Exceptionality	Teacher(s)	Medic Alert I.D.	
	_____	Yes ☐ No ☐	
	_____		
	_____		
Grade	Age	OEN #	

EMERGENCY CONTACT (LIST IN PRIORITY)			
NAME:	RELATIONSHIP	MAIN CONTACT #	ALTERNATE #
1.			
2.			
3.			
4.			

(HAVE ABILITY TO ADD MORE CONTACTS)

TYPE 1 DIABETES SUPPORTS

Name of trained individuals who will provide support with diabetes-related tasks:

Designated Staff:_____

Local Health Integration Network (LHIN) Care Workers (if applicable):

_____

Method of home-school communication:_____

Any other medical condition or allergy? ☐ No ☐ Yes (Please list below)

1. _____
2. _____
3. _____

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 If yes, go directly to page (6): Emergency Procedures**

☐ **No If no, complete below**

ROUTINE	ACTION for TYPE 1 DIABETES
Blood Glucose Monitoring (GM) ☐ student requires trained individual to check BG/read meter ☐ student needs supervision to check BG/read meter ☐ student can independently check BG/read meter	Target Blood Glucose (BG) Range_____ Times to check BG: Check and Record time below ☐ Before **AM** break _____ ☐ At before-school program _____ ☐ Before lunch _____ ☐ Before breakfast program _____ ☐ Before **PM** break _____ ☐ At after-school program _____ ☐ Before leaving school _____ ☐ Before sports or exercise _____ Contact Parent(s)/Guardian(s) if BG is:_____

*Students should be able to check blood glucose anytime, anyplace, respecting their preference for privacy	Parent(s) Guardian(s) Responsibilities: _____ _____ School Responsibilities:_____ _____ Student Responsibilities:_____ _____ Outside Agency Responsibilities:
Nutrition Breaks ☐ student requires supervision during meal times to ensure completion ☐ student can independently manage 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 times for meals/snacks:_____ _____ Parent(s) Guardian(s) Responsibilities_____ _____ School Responsibilities:_____ _____ Student Responsibilities:_____ _____ Special Instructions for meal days/special events_____ _____ _____ Outside Agency Responsibilities:_____ _____

ROUTINE	ACTION
INSULIN **Always double-check the insulin dose before injecting to make sure the appropriate dose has been selected and is dialed correctly into the pen.** ☐ Student does not take insulin at school ☐ Student takes insulin at school by : ☐ Injection ☐ Pump ☐ Insulin is given by: ☐ Student ☐ Student with supervision ☐ Parent/ Guardian ☐ Trained Individual ☐ Nurse *All students with Type 1 diabetes use insulin. Some students will require insulin during the school day, typically before meal/ nutrition breaks * Parent/Guardian should be notified of changes to daily snack or activity time(s)	**Please complete either A or B:** **A. <u>Injection Delivery:</u>** 1. Student must be able to eat according to daily schedule 2. Student must be able to eat all required food sent by parents **3.** Supervision will be required: **Yes** ☐ **No** ☐ 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:_____ _____ Outside Agency Responsibilities _____ Additional Comments _____ **B. <u>Insulin Pump Delivery</u>:** 1. Student must be able to eat according to daily schedule 2. Supervision will be required: **Yes** ☐ **No** ☐ 3. Student must be able to eat all required food sent by parents **OR** 4. Student may independently adjust insulin to accommodate amount of food **Yes** ☐ **No** ☐ Use of insulin pump before each snack/meal **Yes** ☐ **No** ☐ Carbohydrate/insulin ratio: _____

	Student may unhook pump for a maximum of one hour during intense physical activity **Yes ☐** **No ☐** While disconnected pump will be stored: _____ Parent(s) Guardian(s) Responsibilities_____ _____ School Responsibilities:_____ _____ Student Responsibilities:_____ _____ Outside Agency 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 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
DIABETES MANAGEMENT KIT *Parents must provide, maintain, and refresh supplies. School must ensure this kit is accessible at 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: ☐ Supplies: ☐ Blood Glucose meter and strips ☐ Lancing device and lancets ☐ Glucagon Needle ☐ Sharps Disposal Container ☐ For syringe delivery students ☐ Insulin pen/syringe ☐ Insulin ☐ For pump delivery students: Supplies as decided:_____ _____ ☐ Source of fast-acting sugar (e.g. juice, candy glucose tabs) **Fast acting sugars to be stored. Provide specific locations:** In classroom:_____ In office:_____ In gym:_____ ☐ Carbohydrate containing snacks ☐ Other (Please list) _____ Location of supplies:_____ Location of kit:_____ Location of Sharps Disposal Container: _____
SPECIAL NEEDS **A Student with special considerations may require more assistance than outlined in this plan.**	Comments:

ILLNESS
When students with diabetes become ill at school, the parent/guardian/caregiver should be notified immediately so that they can take appropriate action. Nausea and vomiting (flu-like symptoms) and the inability to retain food and fluids are serious situations since food is required to balance the insulin. This can lead to Hypoglycaemia or be the result of hyperglycaemia. Comments:_____ _____ _____

EMERGENCY PROCEDURES
DO NOT LEAVE STUDENT UNATTENDED

HYPOGLYCEMIA – LOW BLOOD GLUCOSE (4 mmol/L OR LESS)

Student will be allowed extra juice/snacks any time they feel low as per hypoglycemic plan

Causes:

- Insufficient carbohydrates due to delayed or missed food
- More exercise than usual without a corresponding increase in food
- Too much insulin

Usual Symptoms of **Hypoglycemia** for my child are: (Select all that apply)

☐ Cold/Clammy/Sweaty skin	☐ Shakiness, poor coordination	☐ Headache
☐ Lack of concentration	☐ Dizziness	☐ Blurred Vision
☐ Reports feeling low	☐ Irritability, Poor behaviour	☐ Weak/Fatigue
☐ Pale	☐ Confused	☐ Hungry

☐ Other:_____

Predicted times/activities common to low blood sugar for my child:

_____

_____

Steps to take for <u>Mild</u> 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, for example _____ 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 EMS arrives.
3. Contact parent(s)/guardian(s) or emergency contact.

HYPERGLYCEMIA – HIGH BLOOD GLUCOSE (14 mmol/L OR ABOVE)

- Blood sugars are 14.0 or above

Causes:

- Too many carbohydrates
- Less than the usual amount of activity
- Not enough insulin
- Illness

Usual Symptoms of **Hyperglycemia** for my child are: (Select all that apply)

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

☐ Other: _____

For pump delivery students: correct with insulin bolus: **Yes** ☐ **No** ☐ **N/A** ☐

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 for Severe Hyperglycemia

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

Consent for student to carry and self-administer Diabetes medication

We agree that _____,
(student name)

☐ can **carry** prescribed medications and delivery devices to manage Diabetes while at school and during school-related activities.

☐ can **self-administer** prescribed medications and delivery devices to manage Diabetes while at school and during school-related activities.

☐ **requires assistance** with administering prescribed medications and delivery devices to manage Diabetes while at school and during school-related activities.

☐ **It is the parent/guardian responsibility to notify the principal if there is a need to change the plan of care during the school year and to inform the school of any change of medication or delivery device**. This medication **cannot** be beyond the expiration date.

Parent/Guardian Name: _____ Signature: _____ Date: _____

Parent/Guardian Name: _____ Signature: _____ Date: _____

Student Name: _____ Signature: _____ Date: _____

Principal Name: _____ Signature: _____ Date: _____

EXCURSION PROTOCOL

Please refer to the Excursion Handbook when planning for excursions and ensure that accommodations are made for the student with Diabetes:
https://www.tcdsb.org/ProgramsServices/SchoolProgramsK12/HealthOutdoorPhysEd/ExcursionHandbook/Documents/Excursion-Handbook-updated-Nov-30-2015.pdf

During all trips off school property, the parent/guardian will provide an excursion kit which will consist of:

☐ A kit for Low Blood Sugar, Hypoglycemia
☐ Emergency Contact
☐ Cell phone (if parent/guardian chooses)

HEALTHCARE PROVIDER INFORMATION (MANDATORY)

To be included by healthcare professional (I.E.: Medical Doctor, Pharmacist, Nurse, or other clinician working within their scope of practice)

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____

Special Instructions/Notes/Prescription Labels/Comments:

_____

_____

_____

- 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 medication **cannot** be beyond the expiration date.
- 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 20___- 20___ 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 and to inform the school of any change of medication or delivery device during the school year.

Consent to treatment: I am aware that school staff are not medical professionals and perform all aspects of the plan to the best of their abilities and in good faith.

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

Student: _____ Date: _____
(signature for student 16 years of age or older)

Principal: _____ Date: _____
(signature)

Student Plan of Care for

EPILEPSY and SEIZURE DISORDER

School Year: 20__- 20__

Student Name	**Date of Birth**	**Gender**	**Student Photo**
Address		**Student #**	
Exceptionality	**Teacher(s)**	**Medic Alert I.D.**	
		Yes ☐ No ☐	
Grade	**Age**	**OEN #**	

EMERGENCY CONTACT (LIST IN PRIORITY)			
NAME:	RELATIONSHIP	MAIN CONTACT #	ALTERNATE #
1.			
2.			
3.			
4.			

(HAVE ABILITY TO ADD MORE CONTACTS)

EPILEPSY AND SEIZURE DISORDER SUPPORTS

Name of trained individuals who will provide support with epilepsy and seizure disorder-related tasks:

Designated Staff:_____

Local Health Integration Network (LHIN) Care Workers (if applicable):
_____

Method of home-school communication:_____

Any other medical condition or allergy? ☐ No ☐ Yes (Please list below)

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 SEIZURE TRIGGERS

✓ **CHECK ALL THOSE THAT APPLY**

☐ Stress	☐ Menstrual Cycle	☐ Inactivity
☐ Changes In Diet	☐ Lack Of Sleep	☐ Electronic Stimulation (TV, Videos, Florescent Lights)
☐ Illness	☐ Improper Medication Balance	
☐ Change In Weather	☐ Other _____	

DAILY ROUTINE EPILEPSY AND SEIZURE DISORDER 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

DO NOT LEAVE STUDENT UNATTENDED

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

ILLNESS
When students with epilepsy have a seizure at school, the parent/guardian/caregiver should be notified immediately so that they can take appropriate action. Comments:_____ _____ _____

EXCURSION PROTOCOL

Please refer to the Excursion Handbook when planning for excursions and ensure that accommodations are made for the student with Epilepsy and Seizure Disorders:

https://www.tcdsb.org/ProgramsServices/SchoolProgramsK12/HealthOutdoorPhysEd/ExcursionHandbook/Documents/Excursion-Handbook-updated-Nov-30-2015.pdf

☐ Emergency Contact
☐ Cell phone (if parent/guardian/caregiver chooses)

HEALTHCARE PROVIDER INFORMATION (MANDATORY)

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/Comments:

_____

_____

_____

_____

_____

- 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 medication **cannot** be beyond the expiration date.
- 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. _____

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 20___- 20___ 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 and to inform the school of any change of medication or delivery device during the school year.

Consent to treatment: I am aware that school staff are not medical professionals and perform all aspects of the plan to the best of their abilities and in good faith.

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

Student: _____ Date: _____
(signature for student 16 years of age or older)

Principal: _____ Date: _____
(signature)

General Student Plan of Care for Other Medical Conditions

Please Specify: _____

School Year: 20__- 20__

Student Name	**Date of Birth**	**Gender**	**Student Photo**
Address		**Student #**	
Exceptionality	**Teacher(s)**	**Medic Alert I.D.**	
		Yes ☐ No ☐	
Grade	**Age**	**OEN #**	

EMERGENCY CONTACT (LIST IN PRIORITY)			
NAME:	RELATIONSHIP	MAIN CONTACT #	ALTERNATE #
1.			
2.			
3.			
4.			

(HAVE ABILITY TO ADD MORE CONTACTS)

SUPPORTS

Name of trained individuals who will provide support with _____-related tasks:

Designated Staff:_____

Local Health Integration Network (LHIN) Care Workers (if applicable):

_____

Method of home-school communication:_____

Any other medical condition or allergy? ☐ No ☐ Yes (Please list below)

1. _____
2. _____
3. _____

HEALTHCARE PROVIDER INFORMATION (MANDATORY)

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/Comments:

_____

_____

_____

_____

_____

- 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 medication **cannot** be beyond the expiration date.
- 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 20___- 20___ 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 and to inform the school of any change of medication or delivery device during the school year.

Consent to treatment: I am aware that school staff are not medical professionals and perform all aspects of the plan to the best of their abilities and in good faith.

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

(signature)

Student: _____ Date: _____

(signature for student 16 years of age or older)

Principal: _____ Date: _____

(signature)

SUPPORTING Ontario Children and Students with Medical Conditions

QUICK FACTS

Supporting children and students at risk for anaphylaxis in Ontario

Promoting child and student well-being is one of the four key goals in "Achieving Excellence: A Renewed Vision for Education in Ontario." Ensuring the health and safety of children and students with medical conditions requires partnership among families, members of the school community and community partners, including health care professionals.

Anaphylaxis overview

Anaphylaxis (pronounced anna-fill-axis) is a serious and possibly life-threatening allergic reaction that requires immediate recognition and intervention. Symptoms can vary from person to person and may include:

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

Food allergy and anaphylaxis facts

- More than 1 million Ontarians are affected by a food allergy.
- There are about 138,000 students in Ontario with food allergies.
- There is no cure for food allergy, so avoidance is still the main way to prevent an allergic reaction.
- Food is one of the most common causes of anaphylaxis, but insect stings, medications, latex and exercise (alone or sometimes after eating a specific food) can also cause reactions.
- The recommended treatment for anaphylaxis is epinephrine (e.g., EpiPen®).

Living with allergies and the risk for anaphylaxis

Families with children who are at risk for anaphylaxis have to plan ahead and take precautionary measures. They can take preventive steps such as:

- being careful when reading food labels;
- avoiding cross-contamination when preparing food; and
- asking questions before eating or drinking foods.

Children who are allergic to stinging insects should avoid areas near nests, particularly during warmer months. It is important that students at risk for anaphylaxis carry epinephrine (e.g., EpiPen®) when age appropriate and/or have it available at their school to be administered in case of a severe reaction. Students at risk for anaphylaxis can participate in all regular school activities. Teachers, staff and administration should be aware of students' medical conditions in case of emergency.

Creating an inclusive environment at school

All children at risk for anaphylaxis — no matter how independent they are — need the support of trusted, caring adults at school and elsewhere.

Sabrina's Law requires all district school boards and school authorities in Ontario to have an anaphylaxis policy in place to support students with potentially life-threatening allergies.

Anaphylaxis can cause a great deal of anxiety for students, families, teachers and other school staff. When speaking to children about anaphylaxis, it is important that they know you are comfortable talking about the issue, or they may keep questions or concerns private.

Ongoing communication between the school, the student and the family is essential, beginning when a student is diagnosed and starts school. Maintaining an open exchange of information is also important throughout the school year, especially if there are changes to the child's medical condition.

Families should work with the school to create an individualized Plan of Care for their child. The plan will include support strategies or ways to accommodate the student (e.g., regular hand washing for all children) so that they can participate to their full potential in school activities.

The Ministry of Education expects all district school boards and school authorities in Ontario to develop and maintain policies to support students with asthma, anaphylaxis, diabetes and epilepsy in schools.

Emergencies

In the case of an emergency related to anaphylaxis, school staff should refer to the child's individualized Plan of Care. In all emergency situations:

1. Stay calm.
2. Give epinephrine auto-injector (e.g., EpiPen®) at the first sign of a known or suspected anaphylactic reaction.
3. Dial 9-1-1.
4. Give a second dose of epinephrine as early as 5 minutes after the first dose if there is no improvement in symptoms.

5. Go to the nearest hospital right away (ideally by ambulance), even if symptoms are mild or have stopped. The reaction could get worse or come back.
6. Inform the emergency contact, as outlined in the student's Plan of Care.

Since anaphylaxis can be life-threatening, it must always be considered a medical emergency and treated promptly. If a child appears to be having an anaphylactic reaction, but you are not sure, it is better to err on the side of caution and use epinephrine. The drug will not cause harm if given unnecessarily to normally healthy children, and side effects are generally mild.

If a child has asthma and is also at risk for anaphylaxis, and it is unclear which emergency the child is experiencing:

1. first give epinephrine (e.g., EpiPen®) and dial 9-1-1 for an ambulance,
2. then give the reliever inhaler (usually a blue inhaler).

Where to find more information

Food Allergy Canada:
http://foodallergycanada.ca/resources/print-materials/

Allergy Aware:
www.allergyaware.ca (Free online courses about food allergy and anaphylaxis for school, child care and community settings)

Sabrina's Law:
https://www.ontario.ca/laws/statute/05s07

Healthy Schools, Ministry of Education:
http://www.edu.gov.on.ca/eng/healthyschools/medicalconditions.html

Developed in partnership with Food Allergy Canada

ISBN 978-1-4868-0886-1 (PDF)

SUPPORTING

Ontario Children and Students with Medical Conditions

QUICK FACTS

Supporting children and students with asthma in Ontario

Promoting child and student well-being is one of the four key goals in "Achieving Excellence: A Renewed Vision for Education in Ontario." Ensuring the health and safety of children and students with medical conditions requires a partnership among families, members of the school community and community partners, including health care professionals.

Asthma overview

Asthma is a common chronic (long-term) lung disease that can make it hard to breathe. People with asthma have extra sensitive airways, that when triggered can tighten up, become swollen, produce extra mucus and make it hard to breathe.

Different people have different asthma symptoms, which can change over time and vary depending on the situation. Common asthma signs and symptoms include:

- shortness of breath
- wheezing (whistling sound from inside the chest)
- difficulty breathing
- chest tightness
- coughing

Asthma facts

- Asthma is typically managed with inhalers or "puffers."
- Asthma can be fatal. In 2013, 259 Canadians died from asthma (100 in Ontario).
- Asthma is most common during childhood and affects at least 13% of Canadian children.
- Over 2 million Ontarians have asthma, including one out of every five children.

Living with asthma

Asthma can't be cured. It is always present even when symptoms aren't. However, asthma can be managed, so that individuals can enjoy a full and active life. In consultation with a health-care professional, an asthma action plan should be developed. This plan outlines:

- What types of medications your children should take;
- Teaching your children to know when their asthma is starting to get out of control and when it is an emergency and what to do in an emergency; and
- Changes to the medications your child takes when having asthma symptoms.

Creating an inclusive environment at school

All children with asthma — no matter how independent they are — need the support of trusted, caring adults at school and elsewhere.

Ryan's Law requires all district school boards and school authorities to develop and maintain a policy to support students with asthma.

Ongoing communication between the school, the student and the family is essential, beginning when a student is diagnosed and starts school. Maintaining an open exchange of information is also important throughout the school year, especially if there are changes to their medical condition.

Families should work with the school to create an individualized Plan of Care for their child. The plan will include support strategies or ways to accommodate the students so that they can participate to their full potential in school activities.

The Ministry of Education expects all district school boards and school authorities in Ontario to develop and maintain policies to support students with asthma, anaphylaxis, diabetes and epilepsy in schools.

Emergencies

In the case of an emergency related to asthma, school staff should refer to the child's individualized Plan of Care. This plan has information about the child's emergency asthma medication, where it is kept, and when it should be used. In an emergency, the child should be taken to the hospital as soon as possible.

In all emergency situations:

1. Stay calm.
2. Immediately use reliever inhaler (usually a blue inhaler).
3. Dial 9-1-1.
4. If the symptoms continue, use the reliever inhaler every 5 - 15 minutes until medical help arrives.
5. Inform the emergency contact, as identified in the student's Plan of Care.

The Lung Association Managing Asthma Attacks poster has general instructions to follow when asthma symptoms increase or become severe.

If a child has asthma and is also at risk for anaphylaxis and it is unclear which emergency the child is experiencing:

1. first give epinephrine (e.g., EpiPen®) and dial 9-1-1 for an ambulance,
2. then give the reliever inhaler (usually a blue inhaler) as indicated above.

Where to find more information

Asthma Canada:
https://www.asthma.ca

The Lung Association – Ontario:
www.lungontario.ca/resources
www.ryanslaw.ca
Lung Health Information Line: 1-888-344-LUNG (5864)

Ryan's Law:

https://www.ontario.ca/laws/statute/15r03

Healthy Schools, Ministry of Education:
http://www.edu.gov.on.ca/eng/healthyschools/medicalconditions.html

Developed in partnership with BREATHE the lung association Asthma.ca Asthma Canada

ISBN 978-1-4868-0887-8 (PDF)

SUPPORTING
Ontario Children and Students with Medical Conditions

QUICK FACTS

Supporting children and students with diabetes in Ontario

Promoting child and student well-being is one of the four key goals in "Achieving Excellence: A Renewed Vision for Education in Ontario." Ensuring the health and safety of children and students with medical conditions requires a partnership among families, members of the school community and community partners, including health care professionals.

Diabetes overview

Type 1 diabetes is a chronic condition where the pancreas stops producing insulin, a hormone that helps the body control the level of glucose (sugar) in your blood. The body produces glucose, and also gets it from foods that contain carbohydrates, such as bread, potatoes, rice, pasta, milk and fruit. Without insulin, glucose builds up in the blood instead of being used by your cells for energy. A lack of insulin can cause both short-term and long-term health problems. Symptoms of undiagnosed type 1 diabetes include:

- increased thirst
- increased urination
- a lack of energy
- weight loss

Type 1 diabetes occurs in about 1 in 300 children in Ontario. The cause of type 1 diabetes is not known. We do know that it is not caused by eating too much sugar, and it cannot be prevented**.** People with type 1 diabetes must receive insulin daily, either by injection or pump.

Type 2 diabetes can also affect children and youth, but it's more common in adults. With type 2 diabetes, the body does not respond well to insulin, and the pancreas cannot produce enough insulin to compensate. Type 2 diabetes can often be managed through changes to diet and lifestyle, as well as with oral medications (pills). Some children with type 2 diabetes may need insulin injections.

Living with diabetes

Blood sugar levels change throughout the day, and are affected by everyday activities like eating, walking, playing sports and writing tests. A healthy pancreas automatically releases just the right amount of insulin to keep blood sugar levels in a healthy range. It constantly adjusts, minute to minute, responding to how much food we eat, activity, stress and other factors.

Giving insulin by injection or through a pump cannot match the precision of a healthy pancreas. No matter how closely people with type 1 diabetes manage the condition, they still experience swings in blood sugar levels. This is why it is important to check blood sugar several times a day.

- If blood sugar goes too low, a fast-acting sugar (like juice or candy) must be consumed to raise blood sugar. Low blood sugar (**hypo**glycemia) can be dangerous if it is not treated right away.
- If blood sugar goes too high, it causes thirst and frequent urination. If high blood sugar (**hyper**glycemia) is left untreated, it can become dangerously high. Children should always be allowed access to water and the bathroom.

Younger children may require hands-on support to help with daily tasks such as checking their blood sugar or administering insulin.

Creating an inclusive environment at school

All children with diabetes — no matter how independent they are — need the support of trusted, caring adults at school and elsewhere.

Children with diabetes can participate in all activities, but may need some advanced planning and additional monitoring. Ongoing communication between the school, the student and the family is essential when a student is diagnosed with diabetes and starts school. Maintaining an open exchange of information remains important throughout the school year, particularly when there are significant changes in diabetes care or school routines.

Families are encouraged to work with the school to create an individualized Plan of Care for their child. The plan will include support strategies or ways to accommodate the students so they can participate to their full potential in school activities.

The Ministry of Education expects all district school boards and school authorities in Ontario to develop and maintain policies to support students with asthma, anaphylaxis, diabetes and epilepsy in schools.

Emergencies

In the case of an emergency related to diabetes, school staff should refer to the child's individualized Plan of Care. This plan has information about the child's condition and emergency contacts.

If mild low blood sugar is not treated right away, it can become severe. A child with severe low blood sugar may be confused, uncooperative (unable/unwilling to take food or drink), unresponsive, unconscious or have a seizure. This is an emergency. It is important to act immediately.

In all emergency situations:

1. Stay calm.
2. Do not leave the student alone.
3. Dial 9-1-1.
4. Inform the emergency contact, as identified in the student's Plan of Care.

Where to find more information

Diabetes at School:
http://www.diabetesatschool.ca/

Healthy Schools, Ministry of Education:
http://www.edu.gov.on.ca/eng/healthyschools/medicalconditions.html

Developed in partnership with

ISBN 978-1-4868-0889-2 PDF (PDF)

www.diabetesatschool.ca

diabetes @School
SAFETY • SUPPORT • SUCCESS

Low blood sugar

Canadian Paediatric Society

What it is and what to do

When blood sugar is below 4 mmol/L, you must act IMMEDIATELY.
Do not leave a student alone if you think blood sugar is low.

Low blood sugar is also called **hypoglycemia.** It can be caused by:

- Too much insulin, and not enough food
- Delaying or missing a meal or a snack
- Not enough food before an activity
- Unplanned activity, without adjusting food or insulin

Some of the most common symptoms of low blood sugar are:


Shakiness

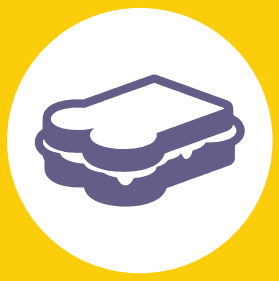

Irritability/grouchiness


Dizziness


Sweating


Blurry vision


Headache


Hunger


Weakness/Fatigue


Pale skin

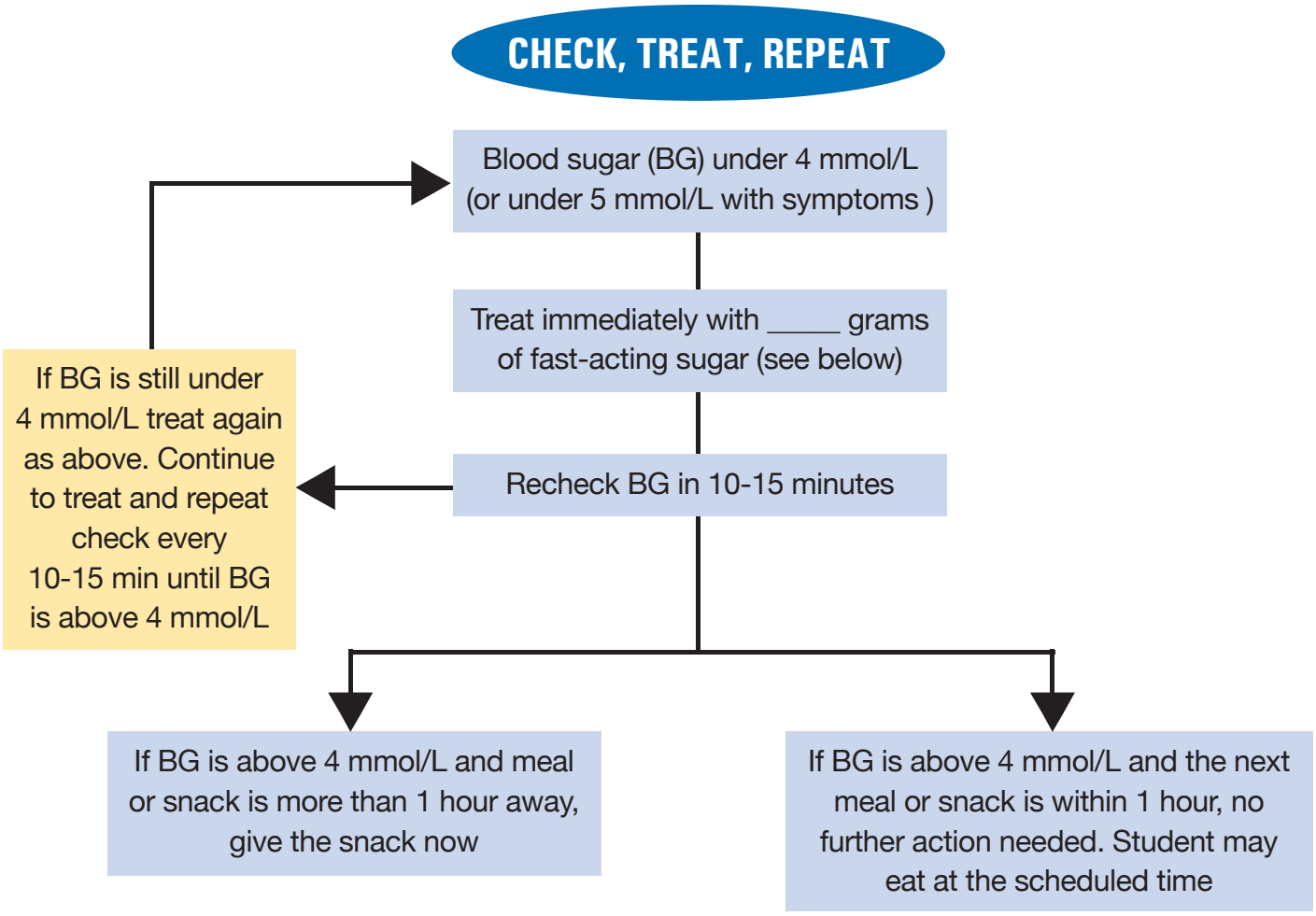

Confusion

See other side for steps to take when you suspect a student has low blood sugar.

How to treat low blood sugar

Remember:

1. Low blood sugar must be treated **IMMEDIATELY**
2. **DO NOT** leave a student alone if you suspect low blood sugar
3. Treat the low blood sugar **WHERE IT OCCURS**. Do not bring the student to another location. Walking may make blood sugar go even lower.
4. Even students who are independent **may need help** when their blood sugar is low



Give fast-acting sugar according to the student's care plan: either 10 g or 15 g

Amount of fast-acting sugar to give		
	10 g	**15 g**
Glucose tablets	2 tablets	4 tablets
Juice/pop	½ cup	¾ cup
Skittles	10 pieces	15 pieces
Rockets candy	1 pkg = 7 g	2 pkgs = 14 g
Table sugar	2 tsp / 2 pkgs	1 Tbsp / 3 pkgs

www.diabetesatschool.ca

diabetes @School
SAFETY • SUPPORT • SUCCESS

High blood sugar

Canadian Paediatric Society

What it is and what to do

High blood sugar (or hyperglycemia) occurs when a student's blood sugar is higher than the target range. It is usually caused by:

- extra food, without extra insulin
- not enough insulin
- decreased activity

Blood sugar also rises because of illness, stress, or excitement. Usually, it is caused by a combination of factors.

Students are not usually in immediate danger from high blood sugar unless they are vomiting, breathing heavily or lethargic. They may have difficulty concentrating in class.

What to do

Check blood sugar. Even students who are independent may need help if they are unwell.

Contact parents immediately if a student is unwell, has severe abdominal pain, nausea, vomiting or symptoms of severe high blood sugar.

If the student is well, follow instructions for high blood sugar in their care plan. Allow unlimited trips to the washroom, and encourage them to drink plenty of water.

Symptoms of high blood sugar


Extreme thirst


Frequent urination


Headache


Hunger


Abdominal pain


Blurry vision


Warm, flushed skin


Irritability

Symptoms of VERY high blood sugar


Rapid, shallow breathing


Vomiting


Fruity breath

If you see these symptoms in a child without type 1 diabetes, please speak to their parents and suggest they see a doctor.

SUPPORTING
Ontario Children and Students with Medical Conditions

QUICK FACTS

Supporting children and students with epilepsy in Ontario

Promoting child and student well-being is one of the four key goals in "Achieving Excellence: A Renewed Vision for Education in Ontario." Ensuring the health and safety of children and students with medical conditions requires a partnership among families, members of the school community and community partners, including health care professionals.

Epilepsy overview

Epilepsy results from sudden bursts of hyperactivity in the brain; this causes "seizures" which vary in form, strength, and frequency, depending on where in the brain abnormal activity is found. **Epilepsy is the diagnosis and seizures are the symptom.** If a person has two or more seizures that are not related to another condition, that person will be diagnosed as having epilepsy.

Epilepsy facts

- Each year 15,500 Canadians are diagnosed as having epilepsy.
- Epilepsy affects over 300,000 Canadians and approximately 1 in 100 Canadian students.
- Seizures can range from a prolonged stare in which the student is fully aware, to a loss of awareness, physical convulsions, or the student's whole body becoming stiff. While surgery is sometimes an option, the most common way of managing epilepsy is single or multiple drug therapies.

Living with epilepsy

When managed effectively an individual with epilepsy can pursue a regular and productive life. Often times, the social anxiety and stigma around epilepsy is more detrimental to an individual's quality of life than the physical symptoms of the condition. Some triggers for epilepsy include alcohol, unmanaged stress and environmental conditions (e.g., flashing lights). When avoiding these triggers, an individual should not be prevented from participating fully in any form of activity. With effective management and accommodation, living with epilepsy should not be a barrier to success.

Creating an inclusive environment at school

All children with epilepsy — no matter how independent they are — need the support of trusted, caring adults at school and elsewhere.

Making children aware of different medical conditions is essential to creating an inclusive environment. Once a child is diagnosed with epilepsy, parents should explain to the child in simple language what the condition is and why it happens. Encouraging children and students to speak to their friends about their condition will help them to find support and understanding amongst their peers.

Ongoing communication between the school, the student and the family is essential when a student is diagnosed with epilepsy and is starting school. Maintaining an open exchange of information is also important throughout the school year, especially if there are changes to the student's medical condition.

Families should work with the school to create an individualized Plan of Care for their child. The plan will include support strategies or ways to accommodate student's so they can participate to their full potential in school activities.

The Ministry of Education expects all district school boards and school authorities in Ontario to develop and maintain policies to support students with asthma, anaphylaxis, diabetes, and epilepsy in schools.

Emergencies

In the case of an emergency related to epilepsy, school staff should refer to the child's individualized Plan of Care. When an epileptic event is happening, it is important to stay calm and support the individual having the seizure. It is not essential to call 9-1-1 when someone is having a seizure; however, if the seizure lasts more than 5 minutes, or repeats without full recovery, seek medical assistance immediately. If you witness a student having a seizure, do not restrain the child, but try to move sharp and cornered objects away in order to prevent injury, and let the seizure run its course.

In all emergency situations:

1. Stay calm.
2. Dial 9-1-1.
3. Inform the student's emergency contact, as outlined in their Plan of Care.

Where to find more information

Epilepsy Ontario:
http://epilepsyontario.org/

Healthy Schools, Ministry of Education:
http://www.edu.gov.on.ca/eng/healthyschools/medicalconditions.html

ISBN 978-1-4868-0888-5 (PDF)

Toronto Catholic District School Board - Exchange of Information for Students

Appendix P

O Elementary to Secondary **O Secondary to Secondary**

(To be completed by the grade 8 Teacher, SS Teacher in consultation with the Special Education Teacher (as applicable) and the School Principal)

THIS DOCUMENT IS INTENDED TO BE AN O.S.R INSERT AND, AS SUCH, IS SUBJECT TO THE SAME SECURITY AND PROTECTION AFFORDED ALL SUCH INFORMATION

"Personal information contained on this form is collected under the authority of Section 170 of the Education Act, R.S.O 1990 and will be used to place the student in secondary school. Questions about this collection should be directed to the school principal or the parent/guardian."

Student Name:

Student D.O.B:

Date of Entry to Canada if applicable:

Current School:

Student O.E.N Number:

New School Applied To:

French in Grade 9:

Requesting Immersion: YES c NO c

Requesting Extended: YES c NO c

Requesting French Exemption: YES c NO c

Special Education

IPRC: YES c NO c

IEP: YES c NO c

Accommodations: YES c NO c

Modifications: YES c NO c

Alternative: YES c NO c

Exceptionality: _____

_____

_____

Class Placement: _____

Referral Pending YES c NO c

SIP Claim YES c NO c

SEA Claim YES c NO c

Transportation YES c NO c

Current Level of Achievement:

1=50-59% 2=60-69% 3=70-79% 4=80-100%

Mathematics Level: 1 c 2 c 3 c 4 c

Grade Level Achieved for IEP Students: _____

Language Arts: 1 c 2 c 3 c 4 c

Grade Level Achieved for IEP Students: _____

Recommended Level of Study in High School

Academic c Applied c

Locally Developed c

Combination c (Please describe below in comments)

Gr. 6 EQAO

R:

W:

M:

Grade 7 CAT 4 Stanine:

Math:

Language:

Reading:

English Language Learners

English Language Learner: YES c NO c

ESL Support: YES c NO c

ELD Support YES c NO c

ELL Step Level of Proficiency:

Current Placement		Secondary Placement	
Step 1	c	ESL/ELD AO	c
Step 2	c	ESL/ELD BO	c
Step 3	c	ESL/ELD CO	c
Step 4	c	ESL/ELD DO	c

* Step 5 and 6 take grade 9 regular applied or Academic English courses

MEDICAL CONDITIONS

Anaphylaxis c Asthma c

Diabetes c Seizures c

Other _____

STUDENT'S STRENGTHS	STUDENT'S CHALLENGES	INTERVENTIONS TO DATE	ACCOMODATIONS and /or MODIFICATIONS IN IEP	SUGGESTED FUTURE *SCHOOL* INTERVENTIONS	SUGGESTED FUTURE *CLASSROOM* INTERVENTIONS
c Attendance/punctuality	c Attendance/punctuality	c Attendance Counsellor	c Tracking homework/assign	c Attendance Counseller	c Class seating arrangement
c Submitting assignments	c Submitting assignments	c Parent conferences	c Resource re: tests/assignments	c Parent conferences	c Set clear expectations
c Homework completion	c Homework completion	c Remedial support	c Extra time for test/assignments	c Remedial support	c Monitor note/homework
c General learning skills	c General learning skills	c Peer mentor/buddy	c Peer helper in class/resource	c Peer mentor/buddy	c Monitor assignment
c Test performance	c Test performance	c Board services support	c Audio tape texts/voice to print	c Board services support	c Daily use of agenda
c Conduct/attitude	c Conduct/attitude	c Community agency	c Study Skills/Modify homework	c Community agency	c Engage in lesson
c Focus and attention	c Focus and attention	c Accommodations	c Photocopied notes	c Accomodations	c "Chunk" assignments
c Co-curricular activities	c "At Risk" activities	c ESL/ELD Support	c Reduction of content as needed	c ESL/ELD Support	c Variety teaching strategies
c Social relationships	c Social relationships	c In-class support	c Oral assessment	c Review student schedule	c Restrict out of class time
c EQAO/ Report Results	c Anxiety/Stress/Health	c Guidance	c Computer Assistance	c Alternative education	c Notify parents re: progress
c Literacy skills	c Motivation	c School Psychologist	c E.A. assistance	c Guidance support	c Ongoing praise/feedback
c Math skills	c EQAO/Report Results	c School Social Worker	c Spell checker/Help with editing	c Review course selection	c In-class peer support
c Self Motivated	Student Plan of Care	c PHAST	c Scribe for notes/tests	c Substitution/deferral	c Curriculum/life experience
c Dance/Drama/Music/Art	Behaviour Safety Plan	c Settlement Worker	c Use of calculator	c Peer/class placement	c Varierty assessment strategies

Student Name:	Student Number:
Comments	

☐ A copy of the Behaviour/Safety Plan has been shared with receiving school. c Transition plan has been completed.

☐ Student Plan of Care has been shared with receiving school.

Copies to: Student OSR c Student Success Teacher c Guidance Teacher c

Parent c Special Education Teacher c ESL Teacher ☐

Sending School Principal Signature: _____ Date: _____

Medical Conditions Staff Training Log

Retain in binder labelled *Medical Conditions*

Training must be completed at *minimum* twice a year

Please check medical conditions that apply:

- ☐ **Anaphylaxis**
- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Epilepsy and Seizure Disorders**
- ☐ **Other**

Date of Training: (DD-MM-YYYY)		**Presenter:**	
Staff Name	**Signature**	**Staff Name**	**Signature**

STUDENT SCHOOL EMERGENCY EVACUATION RESPONSE PLAN

1. STUDENT INFORMATION	
Name:	**EA Name(s)** *(if applicable)* **:**
Grade:	**CYW Name(s)** *(if applicable)* **:**
Daily Schedule and Classroom Locations *(attachment if necessary)***:**	

2. EMERGENCY EVACUATION ASSESSMENT

Does the student experience any of the following that could impede the ability to quickly evacuate the workplace?

a.	Mobility limitations; interference with walking, using stairs, joint pain, use of mobility device (i.e. wheelchair, scooter, cane, crutches, walker, etc.)	☐ yes ☐ no
b.	Vision impairment/loss	☐ yes ☐ no
c.	Hearing impairment/loss	☐ yes ☐ no
d.	Other (please specify):	☐ yes ☐ no

_____
_____
_____
_____
_____
_____
_____
_____

3. COMMUNICATION NEEDS & ACCOMMODATIONS

Indicate the student's preferred method of communication in an emergency situation. List any assistive communication devices and/or accommodations required*. Example: student with hearing impairment may require assistive device to receive emergency evacuation information.*

4. CONDITIONS, SENSITIVITIES, DISABILITIES & ACCOMMODATIONS SUMMARY

Indicate any temporary or long term conditions, sensitivities and/or disabilities that may affect the well-being and safety of the student during emergency response.

Emergency Assistance Required:

5. STUDENT PERSONAL EMERGENCY PREPAREDNESS KIT

Student Personal Emergency Preparedness Kit required? ☐ yes ☐ no

List Contents (i.e. emergency supply of medication, food for specific dietary needs, personal assistive equipment and batteries, emergency health & contact information, etc.):

_____
_____
_____
_____
_____
_____
_____

Location of Student's Personal Emergency Preparedness Kit:

6. EMERGENCY EVACUATION ROUTES

Indicate **primary** accessible evacuation route from workplace, noting any accessibility accommodations required. Where applicable, attach site map/fire safety plan and identify meeting location.

Indicate **alternative** evacuation route from classroom, noting any accessibility accommodations required. Where applicable, attach site map/fire safety plan and identify meeting location.

7. EMERGENCY ASSISTANCE NETWORK

Establish staff to assist the student with a disability during emergencies. Staff should:

- be physically and mentally capable of performing the task and not require assistance themselves
- share the same hours in the same area as the student they will be assisting

The student requiring a School Emergency Evacuation Response Plan should be aware of those who will be notified to assist them during an emergency. **A minimum of 2 people is recommended for the Emergency Assistance Network.**

Network Leader Name: Classroom/Department: Contact Info:	Name: Classroom/Department: Contact Info:
Name: Classroom/Department: Contact Info:	Name: Classroom/Department: Contact Info:

8. ACKNOWLEDGEMENT & RELEASE

Reason for review: ☐ new admission ☐ change in classroom location ☐ change in student's condition

_____ _____

Principal's Signature Date

I acknowledge that the information contained on this form is accurate and hereby authorize Toronto Catholic District School Board to release applicable personal information contained within the Student School Emergency Response Plan to designated individuals within my son's or daughter's Emergency Assistance Network and emergency/first responders, in the event of a school emergency evacuation situation.

_____ _____

Parent's Signature Date

PLEASE ENSURE THAT THE ORIGINAL COMPLETED STUDENT SCHOOL EMERGENCY EVACUATION RESPONSE FORM (WITH ATTACHMENTS) IS ACCESSIBLE TO ALL STAFF IN THE EVENT OF AN EMERGENCY AND A COPY FILED IN THE SCHOOL OFFICE.

All personal information collected on this form and any attachments herein will be used for Student School Emergency Evacuation Response purposes only and will remain confidential as per MFIPPA unless written consent is obtained from the student's parent(s) or guardians (completion of Section 8).

Principal's Action List

Protocols for Prevalent Medical Conditions:
Anaphylaxis, Asthma, Diabetes, Epilepsy/Seizure Disorders, Other Medical Conditions

School Year 20__- 20__

□ Communicate to parent/guardian and appropriate staff the process for parents to notify the school of their child's medical condition(s), at minimum during the time of registration, each year during the first week of school, or when a child is diagnosed and/or returns to school following a diagnosis

□ Co-create, review, or update the Student Plan of Care with the parent/guardian, in consultation with school staff (as appropriate) and with the student (as appropriate) ***during the first 30 school days of every school year*** and for secondary schools that have ***semesters within 30 school days of the start of the term***

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

□ Schedule and participate in training with staff, during instructional day, on prevalent medical conditions, at a minimum bi-annually, as required by the board

□ Maintain a record of training sessions & participants: Medical Conditions Staff Training Log (Appendix Q)

□ Complete the Emergency Evacuation Form (Appendix R)

□ Provide relevant information from the student's Student Plan of Care to school staff and others who are identified in the Student 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 and document the date shared

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

□ Communicate with parent in medical emergencies, as outlined in the Student Plan of Care

□ Ensure that all required forms are completed and signed by the appropriate persons

□ Ensure that all Student Plans of Care are posted in a non-public area of the school (e.g., school office and/or staff room) and that a copy is kept in the teacher's day book (or alternative) and in the information folders prepared for Occasional Teachers and other staff working with the student

□ 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

Appendix T
Sample Parent Letter

Student Plan of Care

Insert Current Date

Dear Parent(s)/Guardian(s):

According to our information, your child requires a ***Student Plan of Care*** for his/her diagnosis of (insert medical condition) if medication is required during the school day.

We will require permission for the administration of this medication at school.

Please complete the attached forms and return them to the school by (insert due date).

Sincerely,

Principal's Name & Title

Encl.