

## **SEVERE MEDICAL CONDITIONS**

### **POLICY**

#### **CONTENTS**

- 1.0 PRINCIPLES**
- 2.0 POLICY FRAMEWORK**
- 3.0 AUTHORIZATION**

#### **1.0 PRINCIPLES**

- 1.1 The Halifax Regional School Board will support the health care needs of students with severe medical conditions.
- 1.2 Only medical procedures determined a necessity in order for the student to attend school may occur during school hours.
- 1.3 The Halifax Regional School Board will maximize the safety of students with severe medical conditions.
- 1.4 The Halifax Regional School Board believes parent(s)/guardian(s) are to be involved in the planning and decision making process with regards to the management of their child's medical condition at school.
- 1.5 The Halifax Regional School Board will collaborate with the IWK and the Capital Health District Health Authority to support students with severe medical conditions.
- 1.6 The confidentiality and dignity of students with severe medical conditions will be respected.

#### **2.0 POLICY FRAMEWORK**

- 2.1 The Halifax Regional School Board is committed to ensuring the care of students with severe medical conditions is in accordance with the *Nova Scotia Education Act*, the following policies and guidelines:
  - 2.1.1 *C.006 Special Education Policy*
  - 2.1.2 *C.009 Administration of Medication Policy*
  - 2.1.3 *B.007 Life-Threatening Allergies Policy*

2.1.4 *Student Records Policy*

2.1.5 *Nova Scotia Education Guidelines for Supporting Students with Type 1 Diabetes (and Other Diabetes Requiring Insulin) in Schools*

### **3.0 AUTHORIZATION**

3.1 The Superintendent is authorized to develop and implement procedures in support of this policy.

## SEVERE MEDICAL CONDITIONS

### PROCEDURES

#### CONTENTS

- 1.0 SEVERE MEDICAL CONDITIONS (including diabetes)
- 2.0 DIABETES (special considerations)
- 3.0 POLICY REVIEW

#### APPENDICES

- A. DEFINITIONS
- B. DIABETES HEALTH CARE PLAN
- C. SEIZURE HEALTH CARE PLAN
- D. ASTHMA HEALTH CARE PLAN
- E. GENERAL HEALTH CARE PLAN (For all other severe medical conditions with the exception of Anaphylaxis; see Anaphylaxis Emergency Plan, *B.007 Life-Threatening Allergies Policy*)
- F. TUBE FEEDING PROCEDURE PLAN
- G. CATERIZATION PROCEDURE PLAN
- H. MEDICAL PROCEDURES TRACKING FORM

#### 1.0 SEVERE MEDICAL CONDITIONS

- 1.1 Principals shall:
  - 1.1.1 Provide the appropriate health care/procedure plan(s) to parent(s)/guardian(s) of student with severe medical conditions at registration and on an annual basis;
  - 1.1.2 Inform all school staff, lunch supervisors and bus drivers of students who have severe medical conditions;
  - 1.1.3 Establish a plan to promptly inform substitutes, student teachers, and volunteers of the students who have severe medical conditions;
  - 1.1.4 Review the plan(s) with school staff;
  - 1.1.5 Post pictures of students and the name of their severe medical condition in the office;
  - 1.1.6 Keep a copy of the student's plan in the office and the original in the

student's cumulative record;

1.1.7 Ensure the plan(s) is made accessible to all staff working with the student identified with a severe medical condition;

1.1.8 Arrange a meeting with the parent(s)/guardian(s) before the first day of school or as soon as possible after the student is diagnosed with a severe medical condition;

1.1.8.1 Establish a communication plan between home and school.

1.1.9 Review the student's plan(s) annually;

1.1.10 Provide support and allocate resources as needed;

1.1.11 Call 9-1-1 in the event of a medical emergency;

1.1.11.1 Support on-site first aid responders in their ability to respond until emergency personnel arrive on scene.

1.1.11.2 Identify the student's Special Patient Protocol Number, if applicable.

1.1.12 Ensure all relevant information pertaining to the student's medical condition is sent to the new school, in the event of a student transfer.

1.2 School staff shall:

1.2.1 Review the plan(s) for their students who have a severe medical condition;

1.2.2 Notify parents in advance of any special activities taking place such as celebrations, sporting events and school trips;

1.2.3 Ensure Routine Practices listed below are followed when there is a potential or actual risk of being exposed to blood, body fluids, secretions or excretions (excluding sweat), mucous membranes, non-intact skin or contaminated equipment:

1.2.3.1 Wash hands with soap and water before and after performing a medical procedure on a student, after handling actual or potentially contaminated equipment or surfaces and immediately after glove removal.

- 1.2.3.2 Wear disposable gloves when touching blood and all body fluids, when touching mucous membranes, and broken skin. Dispose gloves after each single use.
- 1.2.3.3 Disinfect contaminated areas.
- 1.2.3.4 Dispose sharps in a puncture resistant container with a lid (sharps container). Dispose barrier devices (i.e. gloves, items used to clean body fluids or surfaces contaminated with body fluids) in a waste container. Full containers are to be disposed of through a hazardous waste company.
- 1.2.3.5 Report direct exposures of blood or body fluids to the principal.
- 1.2.3.6 Contact a physician in the event of a direct exposure to blood or bodily fluids.
  
- 1.2.4 Complete an entry in the Medical Procedures Tracking Form with each procedure done during school hours.
  
- 1.3 Parent(s)/guardian(s) of students with severe medical conditions shall:
  - 1.3.1 Notify the school of any severe medical conditions and complete the plan(s) on an annual basis;
    - 1.3.1.1 Only medical procedures determined a necessity in order for the student to attend school may occur during school hours.
  - 1.3.2 Provide clear instructions to the school regarding how information pertaining to their child's medical condition and related care are to be communicated;
  - 1.3.3 Provide supplies and equipment related to the care of the medical condition and replenish as needed;
  - 1.3.4 If an alternate plan of care is required, other than the board health care and procedures plan, it must be authorized by a licensed health care professional;
  - 1.3.5 Notify the school immediately if any changes occur to the plan(s);
  - 1.3.6 Provide training to the school when required to support the needs of their child's medical condition while at school;

- 1.3.7 Be encouraged to provide a MedicAlert® bracelet or other means of medical identification for their child.
- 1.3.8 Provide a Special Patient Program ID Card for their child, when applicable;
- 1.3.9 Complete Form A, Administration of Prescribed Medication to Students, *Administration of Medication Policy* in the event a prescribed medication is required during school hours, when applicable.
- 1.4 Students with severe medical conditions shall:
  - 1.4.1 Be encouraged to wear MedicAlert® identification or other means of medical identification at all times throughout the school day, when applicable;
  - 1.4.2 Carry or have access to a Special Patient Program ID Card, when applicable;
  - 1.4.3 Promptly inform an adult when experiencing symptoms related to their medical condition, as age appropriate and according to ability.

## **2.0 DIABETES (special considerations)**

- 2.1 Principals shall:
  - 2.1.1 Support the practice of testing and treating blood sugars;
    - 2.1.1.1 If requested, provide a clean, private area for scheduled blood sugar testing and insulin administration.
    - 2.1.1.2 Ensure a puncture resistant sharps container with a lid is provided.
  - 2.1.2 When noted in the Diabetes Health Care Plan, assign a staff member(s) to be responsible for the daily monitoring of blood glucose levels, insulin pump use and/or supervision of insulin pump use, supervision of meal and snack times, and the daily communication plan with the parent(s)/guardian(s);
  - 2.1.3 Where it is estimated that Emergency Health Services response time to the school is more than 20 minutes, assign two staff members to administer glucagon in case of an emergency;

- 2.1.3.1 Written consent, as provided in the Diabetes Plan(s), to administer glucagon must be obtained from the student's parent(s)/guardian(s) on an annual basis.
- 2.1.3.2 Training of school staff must be completed on an annual basis, in collaboration with parent(s)/guardian(s) and when requested health care professionals.
- 2.1.3.3 Requests from parent(s)/guardian(s) of students with a high risk for hypoglycemia regarding the administration of glucagon in case of emergency where the estimated response time to the school is less than 20 minutes will be supported on an individual, as needed basis, in collaboration with a licensed health care professional(s).
- 2.1.4 If a student's insulin pump site falls out or in the case of a pump malfunction notify the emergency contacts as provided by the parent(s)/guardian(s) immediately;
  - 2.1.4.1 If the student has a new infusion set and can insert independently, provide a clean, private place to do so.
  - 2.1.4.2 If the student has an insulin supply at school and can self-administer, provide a clean, private place to do so, as directed by the parent(s)/guardian(s).
  - 2.1.4.3 Inform parent(s)/guardian(s) that a pump malfunction resulting in their child being without insulin for longer than two hours with a blood sugar level greater than or equal to 15 mmol/L requires their child to be picked up at school.
  - 2.1.4.4 In the event the student is off the pump and without insulin for greater than two hours, has a blood sugar less than 15 mmol/L and is feeling well, implement the plan indicated by parent(s)/guardian(s).
- 2.1.5 Acknowledge that parent(s)/guardian(s) are knowledgeable with regards to the management of their child's diabetes, including knowledge of specific symptoms, appropriate diet, and snacks;
- 2.1.6 Support alternate arrangements organized by the parent(s)/guardian(s) to administer insulin by injection when the parent(s)/guardian(s) are not available.

- 2.2 School staff shall:
- 2.2.1 Support the student to take an appropriate level of responsibility for his/her diabetes care at school as determined in collaboration with the parent(s)/guardian(s);
  - 2.2.2 Notify parent(s)/guardian(s) in advance when food is involved in class activities;
  - 2.2.3 Ensure a second staff member witnesses the dose, when assigned to administer an insulin bolus via an insulin pump;
    - 2.2.3.1 An entry on Form C, Administration of Prescribed Medication Record, shall be completed with each dose of insulin administered and co-signed by the witness.
  - 2.2.4 Support the practice of testing and treating blood sugars in the classroom or in an alternate location if requested;
    - 2.2.4.1 A student with a low blood sugar or feeling unwell shall be treated immediately on site.
  - 2.2.5 When a staff member is assigned to obtain or monitor blood sugar testing, log the blood glucose levels obtained during school hours and share with parent(s)/guardian(s) as indicated in the Diabetes Plan(s);
    - 2.2.5.1 If a staff member obtains the blood glucose level or is required to monitor the level being taken, an entry on Medical Procedures Tracking Form shall be completed.
  - 2.2.6 Notify the principal immediately if the insulin pump site falls out or in the case of a pump malfunction;
  - 2.2.7 Acknowledge that hyperglycemia and hypoglycemia may temporarily affect a student's ability to learn and perform in school.
- 2.3 Parent(s)/guardian(s) of a child with diabetes shall:
- 2.3.1 Provide and replenish the school with supplies for diabetes management at school, including the following:
    - 2.3.1.1 Supply of fast-acting sugar (carbohydrates).

- 2.3.1.2 Safe container for blood sugar monitoring items, insulin injection items and medication labelled with the student's name.
- 2.3.1.3 Glucose monitor and strips, including calibration maintenance.
- 2.3.1.4 Lancet device and lancets.
- 2.3.1.5 Insulin, insulin syringes, and associated supplies.
- 2.3.1.6 Glucagon kit, when deemed necessary.
- 2.3.2 Be responsible for the daily routine administration of insulin injections at school if their child is unable to self-administer insulin;
- 2.3.3 Arrange for their child to be picked up from school in the event of a pump malfunction that results in their child being without insulin for a period greater than two hours during the school day with a blood sugar level greater than or equal to 15 mmol/L, and the child has no other means of receiving insulin.
  - 2.3.3.1 In the event the child is off the pump and without insulin for greater than two hours, is feeling well and the blood sugar level is less than 15 mmol/L, a plan for the remainder of the school day must be communicated to the principal or designate.
- 2.4 Students with diabetes shall:
  - 2.4.1 Manage/act on symptoms of a low blood sugar reaction, with assistance as necessary, as age appropriate and according to ability;
  - 2.4.2 Inform an adult promptly when experiencing symptoms of low blood sugar, or when feeling unwell;
  - 2.4.3 Follow a meal plan and/or only eat food approved by parent(s)/guardian(s);
  - 2.4.4 Participate in blood glucose testing, insulin administration and safe disposal of sharps, as age appropriate and according to ability.

### **3.0 POLICY REVIEW**

- 3.1 This policy will be reviewed every three years.

## APPENDIX A

### Severe Medical Conditions

#### DEFINITIONS

**Blood glucose level:** The amount of sugar in the blood. The blood glucose level is an indicator of the body's ability to balance insulin, food and exercise. A general blood glucose range for school aged children is 4-10 mmol/L, however, this will vary by individual, may change, and is to be determined by the diabetes team.

**Bolus:** A single dose of insulin by pump.

**Diabetes:** A disease that affects the body's ability to make energy from food, due to an imbalance in the production and supply of insulin.

Type 1 Diabetes: the pancreas is unable to produce insulin.

Type 2 Diabetes: the pancreas does not produce enough insulin, or the body does not use insulin effectively.

**Excretion:** Waste substances released from the blood, tissues, or organs. Examples include urine and feces.

**Glucagon Kit:** Consists of a vial of glucagon in the form of a powder, a 1 mL syringe of glycerine (diluting solution), and a container that includes directions.

**Glucagon:** A hormone produced in the pancreas. Glucagon stimulates the liver to release glucose; as blood sugar levels decrease in the body, glucagon works to increase the concentration of sugar in the blood.

*Note:* The drug glucagon is a man-made version of human glucagon. It is used to increase the blood glucose level in cases of severe hypoglycemia (the person is unresponsive, unconscious, having a seizure, or unable to take oral treatment). Glucagon is administered by injection, either subcutaneously (under the skin) or intramuscularly (into a muscle).

**Hyperglycemia:** High blood sugar; levels vary by individual. Symptoms may include frequent urination, blurred vision, feeling hungry, feeling thirsty, abdominal pain, nausea, and/or vomiting.

- Hypoglycemia:** Low blood sugar; level measuring 4mmol/L or less with or without symptoms or less than 5mmol/L with symptoms. Symptoms may include pallor, confusion, diaphoresis (sweating), mood changes, feeling shaky or trembling, and/or feeling hungry. Symptoms of severe hypoglycemia include not being able to take oral treatment, unresponsiveness, unconsciousness, and/or having a seizure.
- Insulin pen:** A device used to inject insulin. It is composed of an insulin cartridge, a dial to measure the dose, and disposable pen needles.
- Insulin pump:** A small device used to deliver a steady amount of rapid-acting insulin (called basal rate), insulin to cover food (called bolus) or insulin to treat high blood sugar (called correction). Insulin is delivered through a plastic tube that is inserted under the skin and secured by tape. Flexible tubing connects the plastic tube to the pump.
- Insulin:** A hormone produced in the pancreas. Insulin stimulates cells of the body to take up glucose (sugars from food), and allows extra sugar to be stored as energy.
- Note:* When the body does not produce insulin, the channels that allow glucose to move into the cells of the body remain closed. Glucose, as a result, remains unused in the body, and unable to enter the cells of the body to make energy. Blood sugar levels will rise, causing symptoms of hyperglycemia (high blood sugar).
- The drug insulin is derived from humans and from animals. Insulin is administered by subcutaneous (under the skin) injection. It is injected to replace the levels in the body, and allow glucose to enter the cells.
- Lancet:** A piece of surgical steel encased in plastic used to puncture the skin to obtain blood to measure blood glucose levels.
- Lancet Device:** A spring loaded device used to pierce the lancet into the skin and retract it.
- Mucous membrane:** Layer of tissue that lines body cavities and passages, including the mouth, nose and eyes.

**Reliever**

**Medication:**

A term used to describe a fast-acting or quick-relief medication. For example, Bricanyl and Salbutamol (Ventolin) are referred to as reliever medications and may be prescribed to treat asthma symptoms in an acute situation. Both of these medications work to relieve symptoms by relaxing the bands of muscle that surround the airways.

**Rescue**

**Medication:**

A term used to describe a fast-acting or quick-relief medication. For example, Buccal Midazolam is referred to as a rescue medication and may be prescribed to give during a seizure to stop and/or shorten its duration.

**Secretion:**

Functional substance released from body cells or glands. Examples include saliva, mucous, and bile.

**Severe medical  
conditions:**

Includes any disease process or disorder that affects a person's airway, breathing, and/or circulation, and when left untreated or improperly treated, could lead to death.



IN PARTNERSHIP WITH



Form to be filled out by parent(s)/guardian(s)

### Diabetes Health Care Plan: Day-to-Day Management Procedures

<b>IDENTIFICATION</b>	Child's Name:		DOB:	Health Card No.:
	Child's Home Address:			
	School:			School Year:
	Grade:	Homeroom teacher:		Photo
	Bus driver and Bus Route No.(if applicable):*for office use			
	MedicAlert® Number:			
	Special Patient Protocol: YES <input type="checkbox"/> NO <input type="checkbox"/>			
	Location(s) of fast acting sugar in the school:*for office use			
	In case of emergency give glucagon: YES <input type="checkbox"/> NO <input type="checkbox"/> *if yes, see signed consent on file, on page 6 of plan			
	Plan effective on: (insert date)			
<b>BLOOD GLUCOSE MONITORING</b>	Target Blood Sugar Range:			
	My child can check blood sugar levels independently: YES <input type="checkbox"/> NO <input type="checkbox"/>			
	If no, name the person who will test the student's blood sugar in school: *for office use			
	Name the person responsible for monitoring blood sugar levels (testing): *for office use			
	Name the person responsible for communicating blood sugar levels to parent: *for office use			
	Can your child recognize when he or she has a low blood sugar? YES <input type="checkbox"/> NO <input type="checkbox"/>			
	Scheduled times to check blood sugar levels during school hours:			
	1.	2.	3.	4.
Identify the method of communication the school is to use to pass on levels to the parent(s)/guardian(s):				

<b>INSULIN BY INJECTION</b>	Call parent(s)/guardian(s) if: (please specify)
	Additional information:
	<b>*Students who use a syringe or pen to administer insulin</b>
	My child can self-administer insulin by injection: YES <input type="checkbox"/> NO <input type="checkbox"/>
	Monitoring required: YES <input type="checkbox"/> NO <input type="checkbox"/>
	If child cannot self-administer, name the person who will administer insulin to my child during school hours:
	Name the person responsible for <u>monitoring</u> insulin administration for this student: *for office use
	Scheduled insulin administration time(s) during school hours:
<b>INSULIN BY PUMP</b>	My child can determine the dose of insulin to be given: YES <input type="checkbox"/> NO <input type="checkbox"/>
	If no, describe the process to be used to determine the dose of insulin to be given during school hours:
	<b>*Students who use a pump for insulin administration</b>
	My child can calculate and administer the correct dose independently: YES <input type="checkbox"/> NO <input type="checkbox"/>
	If no, name the person at school who will use the pump for insulin administration:
	Name the person responsible for monitoring the student using the pump: *for office use
	Scheduled times to bolus insulin on the pump during school hours:
	The person who will provide insulin pump education to school personnel: Parent/Guardian <input type="checkbox"/> Other <input type="checkbox"/> Please specify:
Name the people trained to use the student's insulin pump at school: *for office use	
State how to suspend the insulin pump:	
If the site falls out, the following steps are to be taken in the order written: <ul style="list-style-type: none"> <li>1. Call emergency contacts in the order provided. A new infusion set should be inserted as soon as possible.</li> <li>2. If student has a new infusion set and can insert independently, provide a private place to do so.</li> <li>3. If unable to reach any of the emergency contacts, and a new infusion set is not available to be inserted or the student is unable to insert it themselves, follow the actions stated on the emergency plan, based on the student's symptoms.</li> </ul>	

<b>FOOD MANAGEMENT</b>	My child can eat recess and lunch foods at regular school times: YES <input type="checkbox"/> NO <input type="checkbox"/>
	If no, please specify:
	My child requires a snack prior to bus dismissal: YES <input type="checkbox"/> NO <input type="checkbox"/> *Note: snack is to be provided by parent(s)/guardian(s)
	My child requires a snack at (please specify): *Note: snack is to be provided by parent(s)/guardian(s)
	My child can count carbohydrates: YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>
	If no, describe the process to be used to calculate carbohydrates during school hours, if applicable:
My child requires supervision during meal times to ensure meal completion: YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>GLUCAGON</b>	<b>HRSB Glucagon Procedural Statement:</b>
	Where it is estimated that Emergency Health Services response time to the school is greater than 20 minutes and/or when the student with Type 1 diabetes is determined to be at high risk for severe hypoglycemia, two staff members will be assigned and trained to administer glucagon in the case of an emergency.
<b>GLUCAGON ADMINISTRATION</b>	In the case of an emergency I agree _____ (student's name) is to receive a glucagon injection by trained school staff: YES <input type="checkbox"/> NO <input type="checkbox"/>
	If yes, state the dose to be given:
	Name the people who will provide glucagon training to school staff (if applicable): Parent/Guardian: <input type="checkbox"/> and Health Care Professional <input type="checkbox"/> (please specify):
	School personnel trained to administer glucagon, if applicable: *for office use
	1. _____
	2. _____
Identify location of glucagon kit in school, if applicable: *for office use	



IN PARTNERSHIP WITH



Form to be filled out by parent(s)/guardian(s)

## Diabetes Health Care Plan: Emergency Procedures for Hypoglycemia (Low Blood Sugar)

**Hypoglycemia: Blood sugar 4mmol/l or less with or without symptoms or less than 5mmol/L with symptoms. A person with hypoglycemia (low blood sugar) could have ANY of these signs or symptoms.**

Please check those that typically apply to your child below:

Please note: My child can typically recognize when he or she has a low blood sugar: YES  NO

SYMPTOMS	<p><b><u>MILD TO MODERATE HYPOGLYCEMIA:</u></b></p> <p><input type="checkbox"/> Hungry    <input type="checkbox"/> Sweating    <input type="checkbox"/> Feel shaky, trembling</p> <p><input type="checkbox"/> Pallor    <input type="checkbox"/> Confused    <input type="checkbox"/> Mood changes</p> <p><input type="checkbox"/> Other (please specify): _____</p> <p style="text-align: center;">↓</p>	<p><b><u>SEVERE HYPOGLYCEMIA:</u></b></p> <p>Unable to take oral treatment</p> <p>Unresponsive</p> <p>Unconscious</p> <p>Having a seizure</p> <p style="text-align: center;">↓</p>
ACTION	<p style="text-align: center;"><b><u>Steps In Order:</u></b></p> <p>NOTE: Students should never leave the classroom alone with a low blood sugar. It is recommended to treat low blood sugars in the classroom.</p> <ol style="list-style-type: none"> <li>Instruct student to test blood sugar with glucometer if able. Supervise this action. Blood sugar may need to be obtained by support person.</li> <li>If blood sugar is 4 mmol/L or less with or without symptoms or less than 5mmol/L with symptoms, treat immediately with (please specify):</li> <li>If blood sugar is above 4 mmol/L and student feels unwell, stay with student and notify parent/guardian for further instructions.</li> <li>Repeat blood sugar test 10-15 minutes from treatment time.</li> <li>If blood sugar is less than 4 mmol/L with or without symptoms or less than 5mmol/L with symptoms re-treat as outlined in #2, until blood sugar is greater than 4 mmol/L.</li> <li>If blood sugar is greater than 4mmol/L and meal or snack time is more than 1 hour away, give a snack immediately.</li> <li>If meal or snack time is less than 1 hour away, the student may have their meal or snack at the scheduled time.</li> <li>Call parent(s)/guardian(s) as directed in the diabetes health care plan.</li> </ol>	<p style="text-align: center;"><b><u>Steps In Order:</u></b></p> <ol style="list-style-type: none"> <li>Place student on their side in the recovery position.</li> <li>Have someone call 911.</li> <li>Stay with the student until EHS arrives.</li> <li>If there is a signed consent to give glucagon, give at this time. *Communicate time and dose of glucagon given to EHS.</li> <li>Call parent(s)/guardian(s)/emergency contacts.</li> </ol>



IN PARTNERSHIP WITH



Form to be filled out by parent(s)/guardian(s)

## Diabetes Health Care Plan: Emergency Procedures for Hyperglycemia (High Blood Sugar)

**Hyperglycemia: High blood sugar. Levels vary by individual. Symptoms below are those typical of hyperglycemia.  
Note: Hyperglycemia is not always a result of extra food or poor diabetes management.**

<b>SYMPTOMS</b>	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;">                     Frequent urination Hungry Nausea Abdominal pain                 </td> <td style="width: 50%; vertical-align: top;">                     Blurred Vision Thirsty Vomiting Other:                 </td> </tr> </table>	Frequent urination Hungry Nausea Abdominal pain	Blurred Vision Thirsty Vomiting Other:																						
Frequent urination Hungry Nausea Abdominal pain	Blurred Vision Thirsty Vomiting Other:																								
<b>ACTION</b>	<div style="text-align: center; margin-bottom: 10px;"> <p><b><u>Steps In Order:</u></b></p> </div> <ol style="list-style-type: none"> <li>1. Instruct student to test blood sugar with glucometer if able. Supervise this action. Blood sugar may need to be obtained by support person.</li> <li>2. Call parent(s)/guardian(s) if blood sugar level is greater than or equal to: _____</li> <li>3. If the student is feeling well, and the blood sugar level is below _____, no immediate treatment is required. Allow to resume activity as normal.  Allow student to eat usual meal or snack.  Allow student to access the washroom as necessary; the student will be thirsty and need to urinate frequently.</li> <li>4. Notify parent(s)/guardian(s) immediately if student is feeling unwell, is experiencing severe abdominal pain, is feeling nauseous, or is vomiting. It is recommended the parent(s)/guardian(s) pick up the student from school if the student feels unwell and has a high blood sugar.</li> </ol>																								
<b>EMERGENCY CONTACTS</b>	<p style="text-align: center;"><b>Please prioritize 1, 2, 3 in the order calls are to be placed.</b></p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 20%;">Name</th> <th style="width: 20%;">Relationship</th> <th style="width: 20%;">Home Phone Number</th> <th style="width: 20%;">Work Phone Number</th> <th style="width: 25%;">Cell Phone Number</th> </tr> </thead> <tbody> <tr> <td style="text-align: left;">1.</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: left;">2.</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: left;">3.</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Name	Relationship	Home Phone Number	Work Phone Number	Cell Phone Number	1.						2.						3.					
	Name	Relationship	Home Phone Number	Work Phone Number	Cell Phone Number																				
1.																									
2.																									
3.																									

CONSENT

**Parent/Guardian Authorization Re: Consent to Release Information**

I authorize and hereby consent for school staff to use and/or share information found on this form for purposes related to the education, health and safety of me/my child. This may include:

1. Display of the student's photograph in hard copy or electronic format so that staff, volunteers, and school visitors will be aware of the student's medical condition.
2. Communication with bus operators.
3. Any other circumstances that may be necessary to protect the health and safety of the student.

Parent/Guardian Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian Authorization Re: Consent to Transfer to Hospital**

I authorize and hereby consent for me/my child to be transported to a hospital if required, based on the judgement of school staff. I hereby permit a staff member to accompany my child during transport. Please note: The school principal or designate shall decide if an ambulance is to be called.

Parent/Guardian Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian Authorization Re: Consent for Treatment**

I am aware that school staff are not medical professionals and perform all aspects of the plan to the best of their ability and in good faith. I agree with the responses outlined in Diabetes Health Care Plan, including the administration of glucagon if indicated.

Parent/Guardian Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Note: It is the parent(s)/guardian(s)' responsibility to notify the principal if there is a need to change the Health Care Plan throughout the school year. This authorization may be cancelled upon receipt of written notification to the principal.

**Authorizations:**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name (Print): \_\_\_\_\_

Health Care Professional Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Health Care Professional Name (Print): \_\_\_\_\_

Principal Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Principal Name (Print): \_\_\_\_\_



IN PARTNERSHIP WITH



Form to be filled out by parent(s)/guardian(s)

## Seizure Health Care Plan: Management and Emergency Procedures

IDENTIFICATION	Child's Name:		DOB:	Health Card No.:	
	Child's Home Address:				
	School:			School Year:	
	Grade:	Teacher:		Place Photo Here	
	Bus driver and Bus No. (if applicable): *for office use				
	Medical Diagnosis:				
	Special Patient Protocol: YES <input type="checkbox"/> NO <input type="checkbox"/>				
	MedicAlert® Number:				
	Rescue Medication Ordered: YES <input type="checkbox"/> NO <input type="checkbox"/> *if yes, provide instructions for administration				
	Call the parent(s)/guardian(s) if : (please specify)				
	Does your child have any warning signs before a seizure occurs? YES <input type="checkbox"/> NO <input type="checkbox"/> *if yes, please describe				
	Describe your child's feelings/mood/behaviour after a seizure occurs:				
	Additional information:				
	School staff trained in this student's emergency procedures: *for office use				
1.					
2.					
Plan effective on: (insert date)					

**Seizure: Sudden, abnormal electrical discharge in the brain that results in an alteration in behaviour and/or consciousness.**

Please check symptoms below that typically occur with your child's seizure.

This list is NOT inclusive, and may vary with each seizure.

SYMPTOMS

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Sudden cry or moan                             | <input type="checkbox"/> Cyanosis (skin color turns blue) | <input type="checkbox"/> Choking or gurgling              |
| <input type="checkbox"/> Stiffness (tonic)                              | <input type="checkbox"/> Rhythmic muscle jerks (clonic)   | <input type="checkbox"/> Loss of bladder or bowel control |
| <input type="checkbox"/> Bite tongue or cheek                           | <input type="checkbox"/> Fall with no warning             |   |
| <input type="checkbox"/> Shallow or temporary cessation of respirations |   |   |
| <input type="checkbox"/> Other: _____                                   |   |   |



ACTION

**Steps in Order (for a severe seizure and/or loss of consciousness with a seizure):**

1. Turn student on side or abdomen.
2. Protect student from injury.
3. Provide reassurance.
4. Do not place anything in student's mouth.
5. Do not restrain student.
6. If rescue medication is ordered, give as directed.
7. Call 9-1-1 for a seizure lasting more than 5 minutes, or as directed by parent, physician or special patient protocol: please specify:
8. Call parent(s)/guardian(s).
9. Make the student comfortable. Provide blankets and comfort items as applicable.

\*Do not give food or drink until student is recovered. Student may sleep minutes-hours after seizure.

ADDITIONAL  
INFO.

**Additional information for the school when your child has a less severe seizure. Include what the seizure typically looks like and the action(s) the school staff should take.**

Please prioritize 1, 2, 3 in the order calls are to be placed.				
Name	Relationship	Home Phone No.	Work Phone No.	Cell Phone No.
1.				
2.				
3.				

**CONSENT**

**Parent/Guardian Authorization Re: Consent to Release Information**  
I authorize and hereby consent for school staff to use and/or share information found on this form for purposes related to the education, health and safety of my child. This may include:

1. Display of the student's photograph in hard copy or electronic format so that staff, volunteers, and school visitors will be aware of the student's medical condition.
2. Communication with bus operators.
3. Any other circumstances that may be necessary to protect the health and safety of the student.

Parent/Guardian Signature: \_\_\_\_\_  
Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian Authorization Re: Consent to Transfer to Hospital**  
I authorize and hereby consent for my child to be transported to a hospital if required, based on the judgement of school staff. I hereby permit a staff member to accompany my child during transport. Please note: The school principal or designate shall decide if an ambulance is to be called.

Parent/Guardian Signature: \_\_\_\_\_  
Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian Authorization Re: Consent for Treatment**  
I am aware that school staff are not medical professionals and perform all aspects of the plan to the best of their ability and in good faith. I agree with the responses outlined in the Health Care Plan.

Parent/Guardian Signature: \_\_\_\_\_  
Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Note: It is the parent(s)/guardian(s)' responsibility to notify the principal if there is a need to change the Health Care Plan throughout the school year. This authorization may be cancelled upon receipt of written notification to the principal.

**Authorizations:**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian Name (Print): \_\_\_\_\_  
Health Care Professional Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Health Care Professional Name (Print): \_\_\_\_\_  
Principal Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Principal Name (Print): \_\_\_\_\_



IN PARTNERSHIP WITH



Form to be filled out by parent(s)/guardian(s)

**Asthma Health Care Plan: Management and Emergency Procedures**

<b>IDENTIFICATION</b>	Child's Name:		DOB:	Health Card No.:
	Child's Home Address:			
	School:			School Year:
	Grade:	Classroom Teacher:		Child's Photo
	Bus driver and Bus No. (if applicable) *for office use			
	Special Patient Protocol: YES <input type="checkbox"/> NO <input type="checkbox"/>			
	MedicAlert® Number (if applicable):			
	Time of year your child's asthma is most active:			
	<input type="checkbox"/> Spring <input type="checkbox"/> Fall <input type="checkbox"/> Year round <input type="checkbox"/> Summer <input type="checkbox"/> Winter			
	Please check asthma triggers for your child:			
<input type="checkbox"/> Animal allergy <input type="checkbox"/> Exercise <input type="checkbox"/> Pollen <input type="checkbox"/> Other (please specify): <input type="checkbox"/> Cold <input type="checkbox"/> Mold <input type="checkbox"/> Scents				
Please check the prescribed reliever medication (medicine used during a flare-up):		Please check the device to be used with the reliever medication:		
<input type="checkbox"/> Ventolin <input type="checkbox"/> Bricanyl <input type="checkbox"/> Other (please specify):		<input type="checkbox"/> Spacer with a facemask <input type="checkbox"/> Spacer with a mouthpiece <input type="checkbox"/> Aerosol compressor <input type="checkbox"/> Diskus <input type="checkbox"/> Turbuhaler		
Location of reliever medication in the school: * for office use:				
Please describe strategies that help your child stay calm in the event of an asthma flare-up:				



<b>FLARE-UP</b>	<p style="text-align: center;"><u>Recognizing a Flare-Up of Asthma Symptoms</u></p> <ul style="list-style-type: none"> <li>• Faster breathing</li> <li>• Persistent cough</li> <li>• Wheezing (a high pitched musical sound when breathing)</li> <li>• Complaint of chest feeling tight</li> <li>• Shortness of breath at rest or when talking (can only say 3-5 words between breaths)</li> <li>• The skin is “sucked in” with each breath at the neck and/or around the collar bone</li> <li>• Cough, wheeze or chest tightness during or following exercise</li> <li>• Other symptoms you may notice during a flare-up specific to my child (please list):</li> </ul>
<b>ACTION</b>	<p style="text-align: center;">↓</p> <p style="text-align: center;"><u>Steps in Order:</u></p> <ol style="list-style-type: none"> <li>1. Have the student sit down to rest. <b>DO NOT</b> lay the student down.</li> <li>2. Speak calmly and do not panic. Keep the student calm using techniques specified by the parent(s)/guardian(s).</li> <li>3. Administer a dose of the reliever medicine. <u>Name the medicine and the dose:</u></li> <li>4. Tell the student to take slow, deep breaths.</li> <li>5. Monitor the student for 5-10 minutes.</li> </ol> <p><b>IF SYMPTOMS IMPROVE AND THE STUDENT REPORTS RELIEF OF SYMPTOMS ALLOW THE STUDENT TO RESUME ACTIVITY AS TOLERATED AND NOTIFY THE PARENT(S)/GUARDIAN(S) IF REQUIRED (see notification section)</b></p> <p><b>IF SYMPTOMS REMAIN THE SAME OR WORSEN FOLLOW STEPS 6-7</b></p> <ol style="list-style-type: none"> <li>6. Administer a second dose of the reliever medication. <u>Name the medication and dose:</u></li> <li>7. Monitor the student for 5-10 minutes.</li> </ol> <p><b>IF SYMPTOMS IMPROVE AND THE STUDENT REPORTS RELIEF OF SYMPTOMS ALLOW THE STUDENT TO RESUME ACTIVITY AS TOLERATED AND NOTIFY THE PARENT(S)/GUARDIAN(S) IF REQUIRED (see notification section)</b></p> <p><b>IF SYMPTOMS REMAIN THE SAME OR WORSE, <u>CALL 9-1-1</u> (unless otherwise indicated in the notification section) AND FOLLOW STEPS 8-10</b></p> <ol style="list-style-type: none"> <li>8. Administer the prescribed reliever medication as often as needed until EHS and/or the parent(s)/guardian(s) arrives.</li> <li>9. Stay with the student until EHS and/or the parent(s)/guardian(s) arrives.</li> <li>10. Call the parent(s)/guardian(s) if not previously notified.</li> </ol>

If exercise triggers your child's asthma, please describe the appropriate action for recess or gym activities:

**Please prioritize 1, 2, 3 in the order calls are to be placed.**

EMERGENCY CONTACTS	Name	Relationship	Home Phone No.	Work Phone No.	Cell Phone No.
1.					
2.					
3.					

**CONSENT**

**Parent/Guardian Authorization Re: Consent to Release Information**  
 I authorize and hereby consent for school staff to use and/or share information found on this form for purposes related to the education, health and safety of my child. This may include:

1. Display of the student's photograph in hard copy or electronic format so that staff, volunteers, and school visitors will be aware of the student's medical condition.
2. Communication with bus operators.
3. Any other circumstances that may be necessary to protect the health and safety of the student.

Parent/Guardian Signature: \_\_\_\_\_  
 Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian Authorization Re: Consent to Transfer to Hospital**  
 I authorize and hereby consent for my child to be transported to a hospital if required, based on the judgement of school staff. I hereby permit a staff member to accompany my child during transport. Please note: The school principal or designate shall decide if an ambulance is to be called.

Parent/Guardian Signature: \_\_\_\_\_  
 Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian Authorization Re: Consent for Treatment**  
 I am aware that school staff are not medical professionals and perform all aspects of the Health Care Plan to the best of their ability and in good faith. I agree with the responses outlined in the Health Care Plan.

Parent/Guardian Signature: \_\_\_\_\_  
 Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Note: It is the parent's/guardian's responsibility to notify the principal if there is a need to change the Health Care Plan throughout the school year. This authorization may be cancelled upon receipt of written notification to the principal.

**Authorizations:**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name (Print): \_\_\_\_\_

Health Care Professional Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Health Care Professional Name (Print): \_\_\_\_\_

Principal Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Principal Name (Print): \_\_\_\_\_



IN PARTNERSHIP WITH



Form to be filled out by parent(s)/guardian(s)

**General Health Care Plan: Management and Emergency Procedures**

<b>IDENTIFICATION</b>	Child's Name:		DOB:	Health Card No.:
	Child's Home Address:			
	School:			School Year:
	Grade:	Homeroom Teacher:		Place Photo Here
	Bus driver and Bus No. (if applicable): *for office use			
	Medical Diagnosis:			
	Special Patient Protocol: YES <input type="checkbox"/> NO <input type="checkbox"/>			
	Wears MedicAlert®: YES <input type="checkbox"/> NO <input type="checkbox"/>			
	MedicAlert® Number (if applicable):			
	Please describe any special needs that will require attention during school hours, or that may require emergency medical attention:			
	Medical devices (internal or external), if applicable:			
	List any important rules affecting health and safety that should be followed by your child during school hours (example: activity restrictions):			
	Describe any medication(s) or medical procedure(s) that may be necessary in an emergency:			
List any suggestions helpful for behaviour management (if applicable):				
Additional information:				

	Call parent(s)/guardian(s) if: (please specify)
	Plan effective on: (insert date)
	Trained School Staff in this Student's Health Care Regimen: *for office use
	1.
	2.
	3.
	Person responsible for teaching school staff:  Parent(s)/Guardian(s) <input type="checkbox"/> Other <input type="checkbox"/> (please specify):

**Describe typical symptoms, warning signs, and/or concerns that may indicate your child is experiencing difficulty or that may indicate an emergency situation.**

**Describe the course of action in the spaces provided for each scenario listed.**

SYMPTOMS, WARNING SIGNS AND/OR CONCERNS	<u>First Scenario</u>	<u>Second Scenario</u>	<u>Third Scenario</u>
<b>ACTION</b>	↓  <u>Steps in Order:</u>	↓  <u>Steps in Order:</u>	↓  <u>Steps in Order:</u>

CONSENT

**Parent/Guardian Authorization Re: Consent to Release Information**

I authorize and hereby consent for school staff to use and/or share information found on this form for purposes related to the education, health and safety of my child. This may include:

1. Display of the student's photograph in hard copy or electronic format so that staff, volunteers, and school visitors will be aware of the student's medical condition.
2. Communication with bus operators.
3. Any other circumstances that may be necessary to protect the health and safety of the student.

Parent/Guardian Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian Authorization Re: Consent to Transfer to Hospital**

I authorize and hereby consent for my child to be transported to a hospital if required, based on the judgement of school staff. I hereby permit a staff member to accompany my child during transport. Please note: The school principal or designate shall decide if an ambulance is to be called.

Parent/Guardian Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Parent/Guardian Authorization Re: Consent for Treatment**

I am aware that school staff are not medical professionals and perform all aspects of the plan to the best of their ability and in good faith. I agree with the responses outlined in the Health Care Plan.

Parent(s)/Guardian(s) Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Note: It is the parent(s)/guardian(s)' responsibility to notify the principal if there is a need to change the Health Care Plan throughout the school year. This authorization may be cancelled upon receipt of written notification to the principal.

**Authorizations:**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Name (Print): \_\_\_\_\_

Health Care Professional Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Health Care Professional Name (Print): \_\_\_\_\_

Principal Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Principal Name (Print): \_\_\_\_\_



IN PARTNERSHIP WITH



Form to be filled out by parent(s)/guardian(s)

### Tube Feeding Procedure Plan

<b>IDENTIFICATION</b>	Child's Name:	DOB:	Health Card No.:
	Child's Home Address:		
	School:		School Year:
	Grade:	Homeroom Teacher:	
	Bus driver and Bus No. (if applicable) *for office use		Place Photo Here
	Special Patient Protocol: YES <input type="checkbox"/> NO <input type="checkbox"/>		
	MedicAlert® Number:		
	Can take food by mouth: YES <input type="checkbox"/> NO <input type="checkbox"/>		
	Formula used:		
	Location where formula is stored at school:		
	Length of time formula may be kept in fridge once opened:		
	Amount of water to be used to flush the tube:		
	Additional Information:		
School staff trained on this student's tube feed regimen: *for office use			
1.			
2.			
Plan effective on: (insert date)			
<b>BOLUS FEEDS</b>	<b>*Students who require bolus feeds during school hours</b> (a specific volume delivered at specific times throughout the day)		
	Describe how to give the feed:		
	<b>Tube feeding time(s) during school hours</b>	<b>Volume of formula</b>	<b>Length of time to give the feed over</b>
	1.		
	2.		
3.			
If child is to receive feeds by mouth, please state times, requirements, techniques and/or precautions:			

		Describe cleaning and storage regimen for feeding equipment in school:		
<b>CONTINUOUS</b>	<b>*Students who require continuous feeds during school hours</b>			
	Describe how to give the feed:			
	Rate on pump:			
	Time(s) to rinse the feeding bag and re-prime the tubing during school hours:			
	1.	2.		
		Describe cleaning and storage regimen for feeding equipment in school:		
<b>Gastrostomy Feeding Tube (GT): A tube that passes through the abdomen (belly wall) into the stomach.</b> <b>Jejunostomy Feeding Tube (JT): A tube that passes through the abdomen (belly wall) into the small bowel.</b> <b>*Feeding tubes are used to provide continuous or intermittent nourishment for children unable to eat at all, or not enough to meet their nutritional needs.</b>				
<b>CONCERNS</b>	Student begins to vomit or have diarrhea while feeding.	Student has gas or feels bloated while feeding.	The formula stops dripping well.	The feeding tube becomes dislodged.  *THIS IS AN EMERGENCY SITUATION
	↓	↓	↓	↓
<b>ACTION</b>	<b><u>Steps in Order:</u></b>	<b><u>Steps in Order:</u></b>	<b><u>Steps in Order:</u></b>	<b><u>Steps in Order:</u></b>
	<ol style="list-style-type: none"> <li>1. Stop the feed.</li> <li>2. Clamp the tubing.</li> <li>3. Check the rate and amount of feed left to be administered.</li> <li>4. Call the parent(s)/guardian(s) if there are discrepancies or the student does not stop vomiting.</li> </ol> <p>Note: If the feed is going too fast, especially in the jejunum, it may cause vomiting, diarrhea, cramps, sweating and/or fainting.</p>	<ol style="list-style-type: none"> <li>1. Stop the feed.</li> <li>2. Clamp the tubing.</li> <li>3. Disconnect the feed, keeping both ends clean.</li> <li>4. Elevate the end of the GT.</li> <li>5. Open the end of the tube to allow air to escape (this is called “venting”).</li> <li>6. Re-connect tubing to the student when symptoms are relieved. Unclamp tubing and re-start the feed as ordered by the parent.</li> </ol>	<ol style="list-style-type: none"> <li>1. Check to see if the tube is kinked.</li> <li>2. Reposition the tubing.</li> <li>3. If problem persists, clamp the tubing.</li> <li>4. Disconnect the tube from the student, keeping both ends clean and flush with water as directed to clear any blockage.</li> <li>5. Re-prime the tubing with the formula, unclamp the tubing and re-start the feed as ordered by the parent(s)/guardian(s).</li> </ol>	<ol style="list-style-type: none"> <li>1. Place a clean folded towel over the stoma (opening in the skin).</li> <li>2. Call the parent(s)/guardian(s).</li> <li>3. If the parent(s)/guardian(s) cannot be reached, take the following action: _____ _____ _____</li> </ol>

EMERGENCY CONTACTS	Please prioritize 1, 2, 3 in the order calls are to be placed.				
	Name	Relationship	Home Phone No.	Work Phone No.	Cell Phone No.
	1.				
	2.				
	3.				

CONSENT	<p><b>Parent/Guardian Authorization Re: Consent to Release Information</b> I authorize and hereby consent for school staff to use and/or share information found on this form for purposes related to the education, health and safety of my child. This may include:</p> <ol style="list-style-type: none"> <li>1. Display of the student's photograph in hard copy or electronic format so that staff, volunteers, and school visitors will be aware of the student's medical condition.</li> <li>2. Communication with bus operators.</li> <li>3. Any other circumstances that may be necessary to protect the health and safety of the student.</li> </ol> <p>Parent/Guardian Signature: _____</p> <p>Print Name: _____ Date: _____</p>
	<p><b>Parent/Guardian Authorization Re: Consent to Transfer to Hospital</b> I authorize and hereby consent for my child to be transported to a hospital if required, based on the judgement of school staff. I hereby permit a staff member to accompany my child during transport. Please note: The school principal or designate shall decide if an ambulance is to be called.</p> <p>Parent/Guardian Signature: _____</p> <p>Print Name: _____ Date: _____</p>
	<p><b>Parent/Guardian Authorization Re: Consent for Treatment</b> I am aware that school staff are not medical professionals and perform all aspects of the plan to the best of their ability and in good faith. I agree with the responses outlined in the Procedure Plan.</p> <p>Parent/Guardian Signature: _____</p> <p>Print Name: _____ Date: _____</p> <p>Note: It is the parent's/guardian's responsibility to notify the principal if there is a need to change the Procedure Plan throughout the school year. This authorization may be cancelled upon receipt of written notification to the principal.</p>

<b>Authorizations:</b>	
Parent/Guardian Signature: _____	Date: _____
Parent/Guardian Name (Print): _____	
Health Care Professional Signature: _____	Date: _____
Health Care Professional Name (Print): _____	
Principal Signature: _____	Date: _____
Principal Name (Print): _____	



IN PARTNERSHIP WITH






*Form to be filled out by parent(s)/guardian(s)*  
**Catheterization Procedure Plan**

<b>IDENTIFICATION</b>	Child's Name:		DOB:	Health Card No.:
	Diagnosis:			
	Child's Home Address:			
	School:			School Year:
	Grade:	Homeroom Teacher:		Place Photo Here
	Bus driver and Bus No. (if applicable) *for office use			
	Special Patient Protocol: YES <input type="checkbox"/> NO <input type="checkbox"/>			
	MedicAlert® Number (if applicable):			
	List time(s) the child requires catheterization during school hours:			
	Child can self-catheterize without supervision <input type="checkbox"/>			
	Child can self-catheterize but requires supervision <input type="checkbox"/>			
	Child requires a school staff member perform the catheterization(s) <input type="checkbox"/>			
	Child requires catheterization through: the urethra <input type="checkbox"/> a stoma <input type="checkbox"/>			
	Supplies required:			
<ol style="list-style-type: none"> <li>1. Soap and water or antiseptic hand wash for the staff member</li> <li>2. Gloves</li> <li>3. Cleansing items for the child: wipes or washcloth, soap and water</li> <li>4. Catheter please specify size</li> <li>5. Lubricant</li> <li>6. Container to train the urine if not on the toilet</li> <li>7. Diaper or pad if required</li> <li>8. Other (please specify if necessary):</li> </ol>				
Describe the cleaning and storage regimen for catheterization supplies in school:				
Additional Information:				
School staff trained on this student's catheterization regimen: *for office use				
1.				
2.				
Plan effective on: (insert date)				

**Clean Intermittent Catheterization Definition: The temporary placement of a tube (catheter) into the bladder to remove urine from the body. It is used for medical conditions the cause inadequate bladder emptying.**

<b>CATHETERIZATION VIA URETHRA</b>	<p><b>*Students who require clean intermittent catheterization through the urethra</b></p> <p style="text-align: center;">Steps to Clean Intermittent Catheterization</p> <ol style="list-style-type: none"> <li>1. Wash hands and put on gloves</li> <li>2. Wash the perineal area</li> <li style="padding-left: 20px;">Note: to cleanse, wipe three times: left side, right side, middle</li> <li>3. Lubricate the first two inches of the catheter</li> <li>4. Insert the catheter (see below)</li> <li>5. Drain the urine</li> <li>6. Withdraw the catheter slowly</li> <li>7. Wash the catheter and hands together with soap and water</li> <li>8. Rinse the catheter</li> <li>9. Allow the catheter to air dry</li> <li>10. Store the catheter in a Zip-lock bag</li> <li>11. Store the catheter in a dry place</li> </ol>
	<p>Please describe the process of inserting the catheter in your child's urethra:</p>
<b>CATHETERIZATION VIA STOMA</b>	<p><b>*Students who require clean intermittent catheterization through a stoma</b></p> <p style="text-align: center;">Steps to Catheterizing through a Stoma</p> <ol style="list-style-type: none"> <li>1. Wash hands and put on gloves</li> <li>2. Clean the stoma site</li> <li>3. Lubricate the first two inches of the catheter</li> <li>4. Insert the catheter in the stoma (see below)</li> <li>5. Drain the urine</li> <li>6. Withdraw the catheter slowly</li> <li>7. Wash the catheter and hands together with soap and water</li> <li>8. Rinse the catheter</li> <li>9. Allow the catheter to air dry</li> <li>10. Store the catheter in a Zip-lock bag</li> <li>11. Store the catheter in a dry place</li> </ol>

	Please describe the process of inserting the catheter in your child's stoma:		
<b>SYMPTOMS</b>	Please check symptoms that would require a staff person to notify parent(s)/guardian(s). If another action is preferred, please indicate. <input type="checkbox"/> Unusual pain in back or belly <input type="checkbox"/> Fever <input type="checkbox"/> Blood in the urine <input type="checkbox"/> Foul smelling urine <input type="checkbox"/> Nausea and/or vomiting <input type="checkbox"/> Other:		
<b>Describe typical symptoms, warning signs, and/or concerns that may indicate your child is experiencing difficulty or that may indicate an emergency situation.</b> <b>Describe the course of action in the spaces provided for each scenario listed.</b>			
<b>CONCERNS</b>	<u>First Scenario:</u>	<u>Second Scenario:</u>	<u>Third Scenario:</u>
<b>ACTION</b>	 <u>Steps in Order:</u>	 <u>Steps in Order:</u>	 <u>Steps in Order:</u>

EMERGENCY CONTACTS	Please prioritize 1, 2, 3 in the order calls are to be placed.				
	Name	Relationship	Home Phone No.	Work Phone No.	Cell Phone No.
	1.				
	2.				
3.					

CONSENT	<p><b>Parent/Guardian Authorization Re: Consent to Release Information</b></p> <p>I authorize and hereby consent for school staff to use and/or share information found on this form for purposes related to the education, health and safety of my child. This may include:</p> <ol style="list-style-type: none"> <li>1. Display of the student's photograph in hard copy or electronic format so that staff, volunteers, and school visitors will be aware of the student's medical condition.</li> <li>2. Communication with bus operators.</li> <li>3. Any other circumstances that may be necessary to protect the health and safety of the student.</li> </ol> <p>Parent/Guardian Signature: _____</p> <p>Print Name: _____ Date: _____</p>
	<p><b>Parent/Guardian Authorization Re: Consent to Transfer to Hospital</b></p> <p>I authorize and hereby consent for my child to be transported to a hospital if required, based on the judgement of school staff. I hereby permit a staff member to accompany my child during transport. Please note: The school principal or designate shall decide if an ambulance is to be called.</p> <p>Parent/Guardian Signature: _____</p> <p>Print Name: _____ Date: _____</p>
	<p><b>Parent/Guardian Authorization Re: Consent for Treatment</b></p> <p>I am aware that school staff are not medical professionals and perform all aspects of the plan to the best of their ability and in good faith. I agree with the responses outlined in the Procedure Plan.</p> <p>Parent/Guardian Signature: _____</p> <p>Print Name: _____ Date: _____</p>
	<p>Note: It is the parent's/guardian's responsibility to notify the principal if there is a need to change the Procedure Plan throughout the school year. This authorization may be cancelled upon receipt of written notification to the principal.</p>

<b>Authorizations:</b>	
Parent/Guardian Signature: _____	Date: _____
Parent/Guardian Name (Print): _____	
Health Care Professional Signature: _____	Date: _____
Health Care Professional Name (Print): _____	
Principal Signature: _____	Date: _____
Principal Name (Print): _____	

## MEDICAL PROCEDURES TRACKING FORM TO BE COMPLETED DAILY BY SCHOOL PERSONNEL

Student Name \_\_\_\_\_

Medical procedures to be performed/monitored by:

Name \_\_\_\_\_ Signature \_\_\_\_\_ Initials \_\_\_\_\_

Name \_\_\_\_\_ Signature \_\_\_\_\_ Initials \_\_\_\_\_

Name \_\_\_\_\_ Signature \_\_\_\_\_ Initials \_\_\_\_\_

Parent(s) / Guardian(s) names, home and emergency telephone numbers:

Name \_\_\_\_\_

Home \_\_\_\_\_ Emergency \_\_\_\_\_

Name \_\_\_\_\_

Home \_\_\_\_\_ Emergency \_\_\_\_\_

Date	Time	Medical Procedures	Performed/Monitored by:

	Comments