Date: _____

ANAPHYLAXIS HEALTH CARE PLAN

STUDENT INFORMATION

School: _____

Student Name:_____ Date of Birth:_____

Age:_____ School:_____

Grade:_____ Teacher:_____

Student Photo (Optional)

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 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).

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

Form P662.2, April 2019

Date: _____

KNOWN LIFE-THREATENING TRIGGERS

CHECK (✓) THE APPROPRIATE BOXES

❒ Food(s):_____ ❒ Insect Stings:_____

❒ Other:_____

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

Dosage: ❒ EpiPen® ❒ EpiPen®

Jr. 0.15 mg 0.3 mg Location of Auto-Injector(s):_____

_____

Disposal of unused medication and medical supplies if applicable (supply and disposal of unused medication and/or medical supplies are facilitated by the family):

_____

_____

_____

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

_____

DAILY/ROUTINE ANAPHYLAXIS MANAGEMENT

SYMPTOMS:

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

- **Skin system**: hives, swelling (face, lips, tongue), itching, warmth, redness.
- **Respiratory system** (breathing): coughing, wheezing, shortness of breath, chest pain or tightness, throat tightness, hoarse voice, nasal congestion or hay fever-like symptoms (runny, itchy nose and watery eyes, sneezing), trouble swallowing.
- **Gastrointestinal system** (stomach): nausea, vomiting, diarrhea, pain or cramps.
- **Cardiovascular system** (heart): paler than normal skin color/blue color, 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.

Date: _____

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: _____

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

☐ School Staff

Other Individuals to be Contacted Regarding Plan of Care:

Before-School Program ☐ Yes ☐ No _____

After-School Program ☐ Yes ☐ No _____

School Bus Driver ☐ Route #: _____

Other: _____

Date: _____

This plan remains in effect for the 2020 - 2021 school year without change and will be reviewed on or before: _____ unless otherwise notified by parents of need to revisit the Plan. It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year.

I/We hereby request that the York Region District School Board, its employees or agents, as outlined, administer the above procedure to my/our child. The York Region District School Board employees are expected to support the student's daily or routine management, and respond to medical incidents and medical emergencies that occur during school, as outlined in board policies and procedures.
Parent(s)/guardian(s) acknowledge that the employees of the York Region District School Board, who will administer the related procedures, are not medically trained. At all times it remains the responsibility of the parent(s)/guardian(s) to ensure that clear instructions and current physician's orders are provided to the principal.

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

Principal: _____ Date: _____
Signature

Authorization for the collection of this information is in accordance with the *Education Act*, the *Municipal Freedom of Information and Protection of Privacy Act*, and the *Personal Health Information Protection Act*, as amended and applicable. The purpose is to collect and share medical information and to administer proper medical care in the event of an emergency or life-threatening situation. Users of this information include but are not limited to principals, teachers, support staff, volunteers, and bus drivers. This form will be kept for a minimum period of one calendar year. Contact person concerning this collection is the school principal.

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	Original:	Scanned and uploaded to SSNET
	Original:	Scanned and sent to Student Transportation Services
	Copy:	Parent/Guardian
	Copy:	File in the OSR

RETAIN: Current school year + 1 year

Relevant Forms:

Medical Incident Record Form (accessed via SSNET)

ASTHMA HEALTH CARE PLAN

STUDENT INFORMATION

Date Created:_____

Student Name:_____ Date of Birth:_____

Age:_____ School:_____

Grade:_____ Teacher:_____

Student Photo (Optional)

EMERGENCY PROCEDURES

IF ANY OF THE FOLLOWING OCCUR:

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

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

TAKE ACTION:

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

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

IF ANY OF THE FOLLOWING OCCUR:

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

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_____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.

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

DAILY/ROUTINE ASTHMA MANAGEMENT

RELIEVER INHALER USE AT SCHOOL AND DURING SCHOOL-RELATED ACTIVITIES

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

☐ is a fast-acting medication (usually blue in colour) that is used when someone is having asthma symptoms. The reliever inhaler should be used when student is experiencing asthma symptoms (e.g., trouble breathing, coughing, and wheezing).

☐ Use reliever inhaler_____in the dose of _____

(Name of Medication) (Number of Puffs)

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

☐ Student requires assistance to access reliever inhaler. Inhaler must be readily accessible.

Reliever inhaler is kept:

☐ With:_____ Location:_____ Other Location:_____

☐ Student **will carry** their reliever inhaler **at all times** including during recess, gym, outdoor and off-site activities.

Reliever inhaler is kept in the student's:

☐ Pocket ☐ Backpack/fanny Pack

☐ Case/pouch ☐ Other (specify): _____

Does student require assistance to **administer** reliever inhaler? ☐ Yes ☐ No

☐ Student's **spare** reliever inhaler is kept:

In main office (specify location):_____ Other Location:_____

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 the student will be participating in an overnight activity).

Use/administer_____ In the dose of_____At the following times: _____
(Name of Medication)

Storage and location of spare medication and other supplies if applicable:

_____

_____

Disposal of unused medication and medical supplies if applicable (supply and disposal of unused medication and/or medical supplies are facilitated by the family):

_____

_____

KNOWN ASTHMA TRIGGERS

CHECK ALL THOSE THAT APPLY

❒Colds/Flu/Illness ❒Change In Weather ❒Pet Dander ❒Strong Smells ❒Dust

❒Smoke (e.g. Tobacco,Fire, cannabis, second-handSmoke) ❒Mold ❒Cold Weather

❒Pollen ❒Physical Activity/Exercise ❒Other (Specify): _____

❒At Risk for Anaphylaxis (Specify Allergen): _____

❒Asthma Trigger Avoidance Instructions: _____

_____

❒Any Other Medical Condition or Allergy? _____

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

☐ School Staff

Other Individuals to be Contacted Regarding Plan of Care:

Before-School Program ☐ Yes ☐ No _____

After-School Program ☐ Yes ☐ No _____

School Bus Driver ☐ Route #: _____

Other: _____

This plan remains in effect for the 2020-2021 school year without change and will be reviewed on or before: _____ unless otherwise notified by parents of need to revisit the Plan. It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year.

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

Principal: _____ Date: _____
Signature

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Copy: File in the OSR

RETAIN: Current school year + 1 year

Relevant Forms:

Medical Incident Record Form (accessed via SSNET)

Date: _____

TYPE 1 DIABETES HEALTH CARE PLAN

STUDENT INFORMATION

School: _____

Student Name:_____ Date of Birth:_____

Age:_____ School:_____

Grade:_____ Teacher:_____

Student Photo
(Optional)

EMERGENCY PROCEDURES

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

Usual symptoms of Hypoglycemia for my child are:

❒Shaky	❒Irritable/Grouchy	❒Dizzy	❒Trembling
❒Blurred Vision	❒Headache	❒Hungry	❒Weak/Fatigue
❒Pale	❒Confused	☐ Other_____	

Steps to take for Mild hypoglycemia (student is responsive)

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

Steps for Severe Hypoglycemia (student is unresponsive)

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

HYPERGLYCEMIA-HUIGH BLOOD GLOCOSE
(14 mmol/L or above)

Form P662.4, April 2019

Date: _____

Usual symptoms of Hyperglycemia for my child are:

❒Extreme Thirst ❒Frequent Urination ❒Headache

❒Hungry ❒Abdominal Pain ❒Blurred Vision

❒Warm, Flushed Skin ❒Irritability ☐Other_____

Steps to take for Mild hyperglycemia

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

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

❒Rapid, Shallow Breathing ❒Vomiting ❒Fruity Breath

Steps to take for Severe hyperglycemia

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

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

TYPE 1 DIABETES SUPPORTS

Names of trained individuals who will provide support with diabetes-related tasks: (e.g. student, designated staff, third party health care provider). _____

Method of home-school communication:_____

Any other medical condition or allergy?_____

DAILY/ROUTINE TYPE 1 DIABETES MANAGEMENT

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

❒Yes ❒No

❒ If Yes, go directly to page five (5)-Emergency Procedures

Date: _____

ROUTINE	ACTION
BLOOD GLUCOSE MONITORING ❒Student requires trained Individual to check BG/read meter. ❒Student needs supervision to check BG/read meter. ❒Student can independently check BG/read meter. ❒Student has continuous glucose monitor (CGM) *Student should be able to check blood glucose anytime, anyplace, respecting their preference for privacy.	Target Blood Glucose Range:_____ Time(s) to check BG:_____ Contact Parent(s)/Guardian(s) if BG is:_____ Parent(s)/Guardian(s) Responsibilities:_____ School Responsibilities:_____ _____ Student Responsibilities:_____ _____
NUTRITION BREAKS ❒Student requires supervision During meal times to ensure completion ❒Student can independently Manage his/her food intake *Reasonable accommodation must be made to allow student to eat all of the provided meals and snacks on time. Students should not trade or share food/snacks with other students.	Recommended time(s) for meals/snacks:_____ Parent(s)/Guardian(s) Responsibilities:_____ School Responsibilities:_____ _____ Student Responsibilities:_____ _____ Special instructions for meal days/special events:_____
INSULIN ❒Student does not take insulin at school. ❒Student takes insulin at school by: ❒Injection ❒Pump	Location of insulin:_____ Required times for insulin:_____ ❒Before School ❒Morning Break ❒Lunch Break ❒Afternoon Break ❒Other (Specify):_____

Date: _____

❒Insulin is given by: ❒Student ❒Student with supervision ❒Parent(s)/Guardian(s) ❒Third party health care provider	Parent(s)/Guardian(s) Responsibilities:_____ School Responsibilities:_____
ROUTIN	**ACTION (CONTINUED)**
*All students with Type 1 diabetes use insulin. Some students will require insulin during the school day, typically before meal/nutrition breaks.	Student Responsibilities:_____ Additional Comments:_____
ACTIVITY PLAN Physical activity lowers blood glucose. BG is often checked before activity. Carbohydrates may need to be eaten before/after physical activity. A source of fast-acting sugar must always be within students reach.	Please indicate what this student must do prior to physical activity to help prevent low blood sugar: 1. Before activity:_____ 2. During activity:_____ 3. After activity:_____ Parent(s)/Guardian(s) Responsibilities:_____ School Responsibilities:_____ Student Responsibilities:_____ For special events, notify parent(s)/Guardian(s) in advance so that appropriate adjustments or arrangements can be made. (e.g. extracurricular, Terry Fox Run)
DIABETES MANAGEMENT KIT Parents must provide, maintain, and refresh supplies. School must ensure this kit is accessible all times. (e.g. Field trips, fire drills, lockdowns) and advise parents when supplies are low.	Kits will be available in different locations but will include: ❒ Blood Glucose meter, BG test strips, and lancets. ❒ Insulin and insulin pen and supplies. ❒ Source of fast acting sugar (e.g. juice, candy, glucose tabs). ❒ Other (Please list) _____ _____ Location of Kit: _____

Storage and location of spare medication and other supplies if applicable:

_____

_____

Disposal of unused medication and medical supplies if applicable (supply and disposal of unused medication and/or medical supplies are facilitated by the family):

_____

_____

Date: _____

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

☐ School Staff

Other Individuals to be Contacted Regarding Plan of Care:

Before-School Program ☐ Yes ☐ No _____

After-School Program ☐ Yes ☐ No _____

School Bus Driver ☐ Route #: _____

Other: _____

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

Principal: _____ Date: _____
Signature

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RETAIN: Current school year + 1 year

Relevant Forms:

Self-Administration of Medication

Medical Incident Record Form (accessed via SSNET)

EPILEPSY (Seizure Disorders) HEALTH CARE PLAN

STUDENT INFORMATION

Date Created:_____

Student Name:_____ Date of Birth:_____

Age:_____ School:_____

Grade:_____ Teacher:_____

Student Photo (Optional)

EMERGENCY PROCEDURES

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.

EMERGENCY PROCEDURES

Students with epilepsy will typically experience seizures as a result of their medical condition. Call 9-1-1 when:

- ❒ 1st Convulsive (tonic-colonic) seizure
- ❒ Emergency medication administered, as per their prescription, does not relieve seizure activity
- ❒ Student has repeated seizures without regaining consciousness
- ❒ Student has a first-time seizure
- ❒ Student has breathing difficulties
- ❒ Student has a seizure in water
- ❒ Notify parent(s)/guardian(s) or emergency contact
- ❒ _____

KNOWN SEIZURE TRIGGERS
CHECK ALL THOSE THAT APPLY

❒Stress ❒Menstrual Cycle ❒Inactivity ❒Changes in Diet

❒Lack of Sleep ❒Improper Medication Balance ❒Illness

❒Electronic Stimulation (TV, Videos, Florescent Lights) ❒Changes in Weather

❒Other: _____

❒Any other Medical Conditions and/or Allergy?_____

_____

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

DAILY/ROUTINE SEIZURE MANAGEMENT

Note: it is possible for a student to have more than one seizure type. Record information for each seizure type. (e.g., tonic-colonic, absence, simple partial, complex partial, atonic, myoclonic, and/or infantile spasms)

SEIZURE TYPE	PREVENTATIVE ACTIONS	ACTIONS TO TAKE DURING SEIZURE
Type: Description: Frequency of Seizure Activity: Typical Seizure Duration: Known Triggers:		
Type: Description: Frequency of Seizure Activity: Typical Seizure Duration: Known Triggers:		

Storage and location of spare medication and other supplies if applicable:

_____

Disposal of unused medication and medical supplies if applicable (supply and disposal of unused medication and/or medical supplies are facilitated by the family):

BASIC FIRST AID: CARE AND COMFORT

First Aid procedures:

Does student needs 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

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

☐ School Staff

Other Individuals to be Contacted Regarding Plan of Care:

Before-School Program ☐ Yes ☐ No _____

After-School Program ☐ Yes ☐ No _____

School Bus Driver ☐ Route #: _____

Other: _____

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

Principal: _____ Date: _____
Signature

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	Copy:	File in the OSR

RETAIN: Current school year + 1 year

Relevant Forms:

Staff Administration of Medication Form
Self-Administration of Medication Form
Medical Incident Record Form (accessed via SSNET)

Date: _____

YORK REGION DISTRICT SCHOOL BOARD

STAFF ADMINISTRATION OF MEDICATION

It is the responsibility of parents/guardians to administer medication to their children. Treatment regimens should, where possible, be adjusted to avoid administration of medication during school hours. When this is not possible, parents may request assistance of school personnel through the principal. Students should be encouraged to accept the maximum responsibility for the self-administration of medication. (Policy 662.0, Procedure 662.1).

REQUEST FOR ADMINISTRATION OF MEDICATION (PLEASE TYPE OR PRINT INFORMATION)

A. Student Information:

Name:_____ Date of Birth:_____

Age:_____ School:_____

Grade:_____ Teacher:_____

Physician:_____ Telephone:_____

B. Parents/Guardian Information:

Parent/Guardian #1:_____

Telephone:_____

Parent/Guardian #2:_____

Telephone:_____

C. Medication Information

Name of Medication:_____

Storage Requirement:_____

Dosage and Time to be Given During School Hours:_____

Duration of Medication:_____

Medication must be supplied in the original, clearly labeled container from a registered dispensary. It must include:

- The student's name;
- Date of issue;
- Name of the medication;
- The name of the registered dispensary;
- The prescribed dosage and frequency;
- Period of use; and
- The name of the prescribing licensed physician or nurse practitioner.

Storage and location of spare medication and other supplies if applicable:

_____

_____

Date: _____

Disposal of unused medication and medical supplies if applicable (supply and disposal of unused medication and/or medical supplies are facilitated by the family):

_____

_____

I/We are the parents/guardians of _____

Student's Name

I/We hereby request that the York Region District School Board, its employees or agents, as outlined, administer the above procedure/medication to my/our child. The York Region District School Board employees are expected to support the student's daily or routine management, and respond to medical incidents and medical emergencies that occur during school, as outlined in board policies and procedures. I / W e acknowledge that the employees of the York Region District School Board, who will administer the related procedures/medications, are not medically trained. At all times it remains the responsibility of the Parent(s)/Guardian(s) to ensure that clear instructions and current physician's orders related to the use of the medication are provided to the principal. Parent(s)/Guardian(s) and their children are fully responsible for ensuring that the medication is taken as required. Parent(s)/Guardian(s) have been advised that neither the York Region District School Board, it's employees or agents, accept responsibility for any loss, damage or injury to the student or his/her family arising out of the administration of medication describe above.

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

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

NOTE: This request will terminate on June 30 of each school year. A new form must be completed for any change in the above instructions.

D. APPROVAL OF PRINCIPAL

Principal Signature:_____ Date:_____

Authorization for the collection of this information is in accordance with the *Education Act*, the *Municipal Freedom of Information and Protection of Privacy Act*, and the *Personal Health Information Protection Act*, as amended and applicable. The purpose is to assist with the meeting the health needs of the student. Users of this information include but are not limited to principals, teachers, support staff, volunteers, and bus drivers. This form will be kept for a minimum period of one calendar year. Contact person concerning this collection is the school principal.

FORM P662-02
Revised April 2019

Distribution:
Original Secure location accessible by school staff
Copy to OSR
Copy to Parent(s)

Retain: Minimum period of one calendar year

Date: _____

Date:_____

HEALTH CARE PLAN (OTHER)

This form should be completed for serious health conditions that require emergency procedures and daily routine management.

Diagnosis:_____

_____

_____

Description of the Condition: _____

_____

STUDENT INFORMATION:

School: _____

Student Name:_____ Date of Birth:_____

Age:_____ School:_____

Grade:_____ Teacher:_____

Student Photo (Optional)

EMERGENCY PROCEDURES

IF ANY OF THE FOLLOWING OCCUR:

-
-
-
-

TAKE ACTION:

STEP 1:

STEP 2:

Form P662.2, April 2019

Date:_____

IF ANY OF THE FOLLOWING OCCUR:

-
-
-
-
- Other _____

THIS IS AN EMERGENCY

STEP 1:

Call 9-1-1 for an ambulance. Follow 9-1-1 communication protocol with emergency responders.

STEP 2:

While waiting for medical help to arrive:

- ✓ Stay calm, reassure the student and stay by his/her side.
- ✓ Notify parent(s)/guardian(s) or emergency contact.

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

DAILY/ROUTINE MANAGEMENT

_____

_____

_____

_____

_____

_____

Date:_____

Storage and location of spare medication and other supplies if applicable:

_____

_____

Disposal of unused medication and medical supplies if applicable (supply and disposal of unused medication and/or medical supplies are facilitated by the family):

_____

_____

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

☐ School Staff

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 2020-2021 school year without change and will be reviewed on or before: _____ unless otherwise notified by parents of need to revisit the Plan. (It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year.)

I/We hereby request that the York Region District School Board, its employees or agents, as outlined, administer the above procedure to my/our child. The York Region District School Board employees are expected to support the student's daily or routine management, and respond to medical incidents and medical emergencies that occur during school, as outlined in board policies and procedures. Parent(s)/guardian(s) acknowledge that the employees of the York Region District School Board, who will administer the related procedures, are not medically trained. At all times it remains the responsibility of the parent(s)/guardian(s) to ensure that clear instructions and current physician's orders are provided to the principal.

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

Principal: _____ Date: _____
Signature

Date:_____

Authorization for the collection of this information is in accordance with the *Education Act*, the *Municipal Freedom of Information and Protection of Privacy Act*, and the *Personal Health Information Protection Act*, as amended and applicable. The purpose is to collect and share medical information and to administer proper medical care in the event of an emergency or life-threatening situation. Users of this information include but are not limited to principals, teachers, support staff, volunteers, and bus drivers. This form will be kept for a minimum period of one calendar year. Contact person concerning this collection is the school principal.

Distribution: Original: Secure location accessible by school staff

Original: Scanned and uploaded to SSNET

Original: Scanned and sent to Student

Transportation Services

Copy: Parent/Guardian

Copy: File in the OSR

RETAIN: Current school year + 1 year

Relevant Forms:

Staff Administration of Medicine

Self-Administration of Medicine

Medical Incident Record Form

CONSENT FOR INFORMATION SHARING
STUDENTS AT THE AGE OF MAJORITY

I, _____, a student at_____
(print name) *(print name of school)*

having reached the age of majority (18) understand that I retain responsibility for my school records. This applies to the Ontario Student Record (OSR) as well as any other information about me retained outside of the OSR.

☐ I hereby consent to ongoing parent/guardian access to my school records.

Please identify an emergency contact, name, address and telephone number.

COMPLETE AND RETURN TO GUIDANCE SERVICES.

Name of Emergency Contact (PRINT) _____

Emergency Contact's Telephone Number _____

Student's Signature _____

Date Signed _____

Date of Birth (DD/MM/YYYY) _____

Personal information collected pursuant to the Education Act as amended will be used to provide access to student records as described. Please contact the Information Access and Privacy Office if more information is needed (905-727-0022 ext. 2015).

File: LEG-Consents **Retain:** Retirement + 5 years in OSR

Revised March 2015

Student name _____

Teacher _____

Grade _____

School Start-Up Permissions Form – Secondary

Parents/Guardians and students, read and initial each item and sign the bottom of the form to acknowledge that you understand and will follow the school and Board policies.

☐ **Check this box if student is 18 years of age or older. Students over 18 do not need Parent/Guardian signature.**

Activity Permissions:
Opportunities for activities arise outside the classroom. My child is permitted to participate in the following (please check all that apply):

☐	Excursions/community walks	☐	Clubs (non-athletic)	☐	School dances
☐	Special activities (e.g. school fair)	☐	Intramural sports		

Student initial	Parent/ Guardian Initial	
		Allergies/Medical Conditions: We understand that there are students and staff within our school community who have life-threatening allergies, and agree to practise allergy safe measures. ***Inform the school office if your child has a serious or life-threatening allergy or medical condition.***
		Caring and Safe Schools Policy: We understand and will follow the Caring and Safe Schools Policy. A summary can be found in the Guide to the School Year under Caring and Safe Schools. The full policy is available on the Board website: www.yrdsb.ca/AboutUs/Policy/.
		Code of Student Conduct: We understand that students are expected to follow the School Code of Student Conduct outlined in the School Start-Up Package, on school property **and** during Board or school-sponsored events and activities.
		Lockers: We understand that students who are provided with lockers must abide by the guidelines for locker usage outlined in the School Start-Up Package. Lockers are Board property and may be opened at any time as required.
		School Policies: We have reviewed the school policies in the School Start-Up Package and agree to adhere to them.

		Tobacco/Vaping/Alcohol/Drug-Free Environment: We understand the use of tobacco, electronic products (such as vaping, electronic cigarettes and cigars and related products, and/or student possession of alcohol/illegal and restricted drugs, including cannabis, are prohibited on school property or within 20 metres of school boundaries, and that this also applies during Board or school-sponsored events and activities. In accordance with the Smoke- Free Ontario Act (SFOA), exceptions are made for the traditional use of tobacco that forms part of Indigenous culture and spirituality.
		Use of Non-Board Electronic Devices: We understand the school policy on portable electronic devices outlined in the School Start-Up Package and in the Guide to the School Year and agree to adhere to the policy.
		Use of Technology Agreement: We understand and will follow the Use of Technology Agreement outlined in the Guide to the School Year under Technology Use and available on the Board website: www.yrdsb.ca/Programs/SafeSchools/Documents/InformationTechnology-AUAgreement.pdf.

Absenteeism

The safety of our students is important to us. If you are planning an absence for your child during the year (family obligations/vacation/faith day, etc.), please indicate the date and reason below.

Date	Reason

Parent/Guardian Name (print): _____

Parent/Guardian Signature: _____

Date: _____

Personal information collected pursuant to the Education Act as amended will be used to provide access to student records as described. Please contact the Information Access and Privacy Office if more information is needed (905-727-0022 ext. 2015).

File: LEG-Consents June 2020

Retain: 12 months from date signed in the school office.