Halifax Regional School Board

CODE: C.011
Program

Medical Conditions – Assigned Health Care Needs of Students Policy

Policy Overview

This policy supports staff and families in the process of providing safe, consistent, and coordinated care of children diagnosed with a medical condition, and who require staff to participate in the child's management and/or emergency care plan while at school. It provides evidenced-informed strategies to assist staff in their capacity to support assigned health care needs in the school setting.

Table of Contents

Policy and Procedures History

- Policy approved June 22, 2011
- Procedures approved June 22, 2012
- Policy revised October 25, 2017
- Procedures revised October 25, 2017

1.0 Legislative Context

1.1 The Assigned Health Care Needs of Students Policy aligns and complies with the following:

1.1.1 *HRSB C.006 Special Education Policy*
1.1.2 *HRSB C.009 Administration of Medication to Students by School Personnel Policy*
1.1.3 *HRSB C.012 Life-Threatening Allergies Policy*
1.1.4 Student Records Policy
1.1.5 Nova Scotia Education Guidelines for Supporting Students with Type 1 Diabetes (and Other Diabetes Requiring Insulin) in Schools
1.1.6 Nova Scotia Education Guidelines for Supporting Students in School who have a Do Not Attempt Resuscitation (DNAR) Order

2.0 Principles

2.1 The Halifax Regional School Board will support the predictable health care needs of students with diagnosed medical conditions.

2.2 Only medical procedures determined a necessity in order for the student to attend school may occur during school hours.

2.3 The Halifax Regional School Board will maximize the safety of students with medical conditions/specific health care needs.

2.4 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.

2.5 The Halifax Regional School Board will collaborate with the IWK and the Nova Scotia Health Authority to support students with medical conditions/specific health care needs.

2.6 The confidentiality and dignity of students with medical conditions/specific health care needs will be respected.

3.0 Authorization

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

4.0 Policy Review

4.1 This policy will be reviewed every five (5) years or on an as needed basis.

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Medical Conditions – Assigned Health Care Needs of Students Procedures

Table of Contents

1.0 Medical Conditions/Specific Health Care Needs

1.1 Principals shall:

1.1.1 Provide the appropriate health and/or emergency care plan(s) to parent(s)/guardian(s) of student with medical conditions/specific health care needs at registration and on an annual basis;

1.1.1.1 A health and/or emergency care plan is required when staff are assigned specific health care needs.

1.1.2 Coordinate training with parents and regulated health care professionals as needed;

1.1.2.1 Collaborate with the Coordinator for Students with Health Care Needs as needed.

1.1.3 Inform all school staff, lunch supervisors and bus drivers of students who have medical conditions/specific health care needs;

1.1.4 Establish a plan to promptly inform substitutes, student teachers, and volunteers of the students who have medical conditions/specific health care needs;

1.1.5 Review the plan(s) with school staff;

1.1.6 Post pictures of students and the name of their medical condition in the office;

1.1.7 Upload a copy of the student's plan in TIENET;

1.1.8 Ensure the plan(s) is made accessible to all staff working with the student identified with a medical condition and those who are assigned the specific health care need(s);

1.1.9 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 medical condition, when staff are assigned specific health care need(s);

1.1.9.1 Establish a communication plan between home and school.

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

1.1.11 Provide support and allocate resources as needed;

1.1.11.1 Assignment is appropriate when the assigned health care need/intervention falls within the provider's role description and training.

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

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

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

1.2 School staff shall:

1.2.1 Review the plan(s) for their students who have a medical condition/specific health care needs;

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 a Tracking Form with each procedure done during school hours.

1.3 Parent(s)/guardian(s) of students with medical conditions/specific health care needs shall**:**

1.3.1 Notify school staff of any medical conditions/specific health care needs and complete the plan(s) on an annual basis when staff are assigned to support the child;

1.3.1.1 Only medical procedures determined a necessity in order for the child to attend school may occur during school hours.

1.3.2 Provide clear instructions to school staff 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/or emergency plan(s), it must be authorized by a regulated health care professional;

1.3.5 Notify school staff immediately if any changes occur to the plan(s);

1.3.6 Provide training to school staff 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 Medication to Students, (*Administration of Medication to Students by School Personnel Policy)* in the event a prescribed medication is required during school hours, when applicable.

1.4 Students with medical conditions/specific health care needs 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.

1.5 Promptly inform an adult when experiencing symptoms related to their medical condition, as age appropriate and according to ability. Share information with staff about the medical condition/assigned health care needs; let staff know how they can best help, as age appropriate and according to ability;

1.6 Work together with staff and participate in procedures, 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 Management and Emergency Care Plan, assign a staff member(s) to be responsible for the daily monitoring of blood glucose levels, continuous glucose monitoring systems, supervision of insulin injections, 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);

2.1.2.1 Support must be assigned during school hours including outdoor activities, and during school trips.

2.1.3 Where it is expected that Emergency Health Services response time to the school is more than 20 minutes, assign staff members to administer glucagon in response to a severe hypoglycemic event;

2.1.3.1 Written consent, as provided in the Diabetes Management and Emergency Care Plan, 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 regulated health care professionals.

2.1.3.3 A minimum of two staff members trained to administer glucagon must be on site each day at school.

2.1.3.4 Requests from parent(s)/guardian(s) of students with diabetes to include administration of glucagon in their child's emergency care plan where the expected response time to the school is less than 20 minutes will be supported on an individual, as needed basis, in collaboration with a regulated health care professional(s), recognizing that giving intramuscular glucagon is the optimal treatment for a severe hypoglycemic event.

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 Allow time for meal completeness and provide proper timing of meals and snacks.

2.2.3 Notify parent(s)/guardian(s) in advance when food is involved in class activities;

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.

2.2.4.2 Allow students to have access to snacks (hypoglycemia treatment) and blood glucose monitoring equipment during exams or tests, in case of hypoglycemic episodes.

2.2.5 When staff are assigned the task of supervising the child perform blood

glucose checks, or checking the continuous glucose monitoring (CGM) system, all levels must be recorded in a logbook and shared with parent(s)/guardian(s) as indicated in the Diabetes Management and Emergency Plan;

2.2.5.1 Staff may be assigned the task of performing blood glucose checks if there is mutual agreement with the parent/guardian and training is provided.

2.2.5.2 When staff are assigned the task of monitoring a CGM system, instructions for obtaining blood glucose readings by meter must be provided.

2.2.6 Support the process of insulin administration;

2.2.6.1 When a staff member is assigned to participate in the operation of an insulin pump, the pump must be programmed so that the pump calculates the dose of insulin based on the carbohydrates and/or blood glucose entered;

2.2.6.1.1 Pump training with school staff must be done in collaboration with a regulated health care professional and the parent/guardian on an annual basis.

2.2.6.2 Ensure a second staff member witnesses the dose, when assigned to administer an insulin bolus via an insulin pump;

2.2.6.2.1 When a child is determined capable to operate the insulin pump with supervision, the staff person will witness the entries.

2.2.6.3 When a staff member is assigned to monitor the dose of insulin administered by injection, the dose must be determined by the parent/guardian.

2.2.6.3.1 An algorithm may be provided by the parent to determine the dose based on the pre-meal blood glucose level.

2.2.6.4 Each dose of insulin administered must be documented and co-signed by a witness on a Tracking Form.

2.2.7 When a staff member is assigned to obtain or monitor blood sugar testing, or glucose levels by CGM, log the levels obtained during school hours.

2.2.7.1 If a staff member obtains the blood glucose level/glucose level

or is required to monitor the level being taken, an entry shall be documented on a Tracking Form.

2.2.8 Notify the principal immediately if the insulin pump site falls out or in the case of a pump malfunction;

2.2.9 Acknowledge that hyperglycemia and hypoglycemia may temporarily affect a student's ability to learn and perform in school.

2.2.10 Provide accommodations during testing and assessment times to allow for cognitive recovery time (approximately 30-60 minutes) from hypoglycemia, as applicable.

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 establishing realistic alarm setting on continuous glucose monitoring systems as needed.

2.3.2.1 Alarms must be set so that they will appropriately demand attention and intervention;

2.3.2.2 Staff cannot be assigned the task of observing CGM systems for trending glucose values;

2.3.2.3 Provide specific instructions for indications to check blood glucose levels by meter.

2.3.3 Be responsible for carbohydrate counting, and weighing of food, as needed.

2.3.3.1 When staff are assigned to monitor food eaten by the child for the purpose of entering a carbohydrate count into the pump, the parent/guardian must send in a log sheet daily with foods itemized with the corresponding carbohydrate count.

2.3.3.2 Be responsible for programming their child's insulin pump so that the pump calculates the dose of insulin based on the carbohydrates and/or blood glucose entered, if staff are assigned to support the child to administer boluses or corrections;

2.3.4 Be responsible for the daily routine administration of insulin injections at school if their child is unable to self-administer insulin;

2.3.5 Be accessible at all times during school hours in the event school staff have insulin pump related questions, or a pump related issue occurs during the school day, when applicable;

2.3.6 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.

2.3.6.1 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 Implementation and Maintenance of an Automated External Defibrillator (AED) (special considerations)

3.1 Principals shall:

3.1.1 Coordinate plan for purchase and implementation when it is determined defibrillation therapy is an established aspect of care for a specific student(s);

3.1.1.1 Forward medical documentation to the Coordinator for Students with Health Care Needs, who will then facilitate the purchase and subsequent training.

3.1.1.1.1 Equipment needs for children 8 years and younger, or 55 lbs and less, include: AED battery, two set of pediatric electrodes, two sets of adult electrodes.

3.1.1.1.2 Equipment needs for children older than 8 years, or greater than 55 lbs, include: AED, battery one set of pediatric electrodes, two sets of adult electrodes.

3.1.1.2 Consult the unit facilitator to discuss a payment plan to cover the cost of the AED and associated equipment.

3.1.1.3 Consult the school administration supervisor to establish an implementation plan when an AED is donated to a specific site.

3.1.2 Coordinate a plan for storage, when an AED is purchased for the school;

3.1.2.1 Choose a location that best suits the building; the location must be clearly labeled, safe, unlocked, and accessible to students and staff, this area should be clear of clutter and kept clean.

3.1.2.2 Inform all staff of the location of the AED.

3.1.3 Coordinate a plan for maintenance of the AED, when a device has been placed in the school;

3.1.3.1 Maintain a user checklist, documenting safety checks, expiration dates (e.g. battery and electrode pads), and any issues with the device.

3.1.3.2 Weekly, or as determined by the manufacturer, check the AED to ensure it is fully functioning and ready to use; this includes:

3.1.3.2.1 a status check on the device;

3.1.3.2.2 ensuring all electrode pads are stored and current;

3.1.3.2.3 an exterior check ensuring the device and the connector are free of dirt and contamination.

3.1.3.3 Report all malfunctioning and/or missing equipment to the provider company immediately; a loaner, or replacement part (s) must be issued.

3.1.3.4 Report all expired equipment (e.g. batteries and electrode pads) to the provider company one month prior to the expiration date, and order replacement parts as needed.

3.1.3.5 Report all usages to the provider company, and request a post-usage inspection; this includes replacing all equipment that was used or opened.

3.1.3.6 Consult the unit facilitator to discuss plan of payment for all maintenance costs associated with the AED.

3.1.4 Coordinate a training plan for staff, as applicable;

3.1.4.1 Assign dedicated staff to be trained and certified in AED use; training includes annual review of the device by the Provider Company (or manufacturer video) and valid CPR certification for both in pediatric and adult.

3.1.4.2 Ensuring the proper amount of staff members be trained and certified so that at least two trained people are present in school all the time.

3.1.4.3 Maintain documentation for staff who are trained and certified, and ensure names are visible to all staff.

3.1.4.4 If a trained person leaves the school, then replacement person should be trained and certified.

3.2 Parent(s)/guardian(s) shall:

3.2.1 Obtain and provide medical documentation to the school, when it is determined defibrillation therapy is an established aspect of care for the child.

3.2.1.1 Documentation must include the child's name, diagnosis, and risk factors that require the child to have immediate access to defibrillation while attending school.

3.2.2 Provide staff with an up-to-date weight of the child to facilitate the purchase of proper electrodes.

4.0 Do Not Attempt Resuscitation (DNAR) Orders (special considerations)

4.1 Principals shall:

4.1.1 Ensure the health and emergency care plan include the "Do Not Attempt Resuscitation" order, when a parent/guardian asks if school staff will honor this request.

4.1.2 Ensure the medical plan of care is filed, in addition to the board health and emergency care plan.

4.1.2.1 A medical plan of care that includes a Do Not Attempt Resuscitation order will include what actions should and should not be done in the event the student experiences cardio-respiratory compromise. The medical plan of care must be signed by a physician.

4.1.2.2 Provide paramedics with a copy of the medical plan of care in the event 9-1-1 is called.

Appendix A
Definitions

Assignment: Appointment of specific health care responsibilities or interventions that are within the care provider's job description (College of Registered Nurses of Nova Scotia)

Automated External Defibrillator (AED): A portable, safe and easy-to-use device for assessing and restarting the heartbeat. An AED will read the heart rhythm and advise the delivery of an electrical shock to the heart only if needed. Early access and use of AED has improved the survival from incidents of sudden cardiac arrest.

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.

Continuous Glucose Monitoring System: A sensor that is inserted under the skin that will evaluate the amount of glucose in the interstitial fluid every five minutes. This sensor does NOT measure the blood glucose level. The purpose of the CGM system will vary by individual (e.g. to identify trends in glucose levels is one common purpose), and may be device specific.

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.

IN PARTNERSHIP WITH IWK Health Centre

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

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

IDENTIFICATION

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 ☐ NO ☐			
Plan effective on: (insert date)			

BLOOD GLUCOSE MONITORING

Target Blood Sugar Range:				
My child can check blood sugar levels independently: YES ☐ NO ☐				
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 ☐ NO ☐				
Location(s) of fast acting sugar in the school:*for office use				
Scheduled times to check blood sugar levels during school hours:				
1.	2.	3.	4.	5.
Identify the method of communication the school is to use to pass on levels to the parent(s)/guardian(s):				

	Call parent(s)/guardian(s) if: (please specify)
	Additional information:
INSULIN BY INJECTION	***Students who use a syringe or pen to administer insulin**
	My child can self-administer insulin by injection: YES ☐ NO ☐ Monitoring required: YES ☐ NO ☐
	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:
	My child can determine the dose of insulin to be given: YES ☐ NO ☐ If no, describe the process to be used to determine the dose of insulin to be given during school hours:
INSULIN BY PUMP	***Students who use a pump for insulin administration**
	My child can calculate and administer the correct dose independently: YES ☐ NO ☐
	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 ☐ Other ☐ 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: 1. Call emergency contacts in the order provided. A new infusion set should be inserted as soon as possible. 2. If student has a new infusion set and can insert independently, provide a private place to do so. 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.

FOOD MANAGEMENT	My child can eat recess and lunch foods at regular school times: YES ☐ NO ☐
	If no, please specify:
	My child requires a snack prior to bus dismissal: YES ☐ NO ☐ *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 ☐ NO ☐ N/A ☐
	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 ☐ NO ☐
GLUCAGON ADMINISTRATION	**HRSB Glucagon Procedural Statement:** 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.
	In case of emergency give glucagon: YES ☐ NO ☐ *Check "yes" only if it has been determined a requirement based on HRSB Severe Medical Conditions Policy and Procedures.
	In the case of an emergency I agree _____ (student's name) is to receive a glucagon injection by trained school staff: YES ☐ NO ☐
	If yes, state the dose to be given:
	Name the people who will provide glucagon training to school staff (if applicable): Parent/Guardian: ☐ and Health Care Professional ☐ (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

MILD TO MODERATE HYPOGLYCEMIA:	SEVERE HYPOGLYCEMIA:
☐ Hungry ☐ Sweating ☐ Feel shaky, trembling	Unable to take oral treatment
☐ Pallor ☐ Confused ☐ Mood changes	Unresponsive
☐ Other (please specify): _____	Unconscious
	Having a seizure

ACTION

Steps In Order:	Steps In Order:
NOTE: Students should never leave the classroom alone with a low blood sugar. It is recommended to treat low blood sugars in the classroom.	1. Place student on their side in the recovery position.
1. Instruct student to test blood sugar with glucometer if able. Supervise this action. Blood sugar may need to be obtained by support person.	2. Have someone call 911.
2. 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):	3. Stay with the student until EHS arrives.
3. If blood sugar is above 4 mmol/L and student feels unwell, stay with student and notify parent/guardian for further instructions.	4. If there is a signed consent to give glucagon, give at this time. Please Check: YES ☐ NO ☐ If yes, communicate time and dose of glucagon given to EHS.
4. Repeat blood sugar test 10-15 minutes from treatment time.	5. Call parent(s)/guardian(s)/emergency contacts.
5. 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.	
6. If blood sugar is greater than 4mmol/L and meal or snack time is more than 1 hour away, give a snack immediately.	
7. If meal or snack time is less than 1 hour away, the student may have their meal or snack at the scheduled time.	
8. Call parent(s)/guardian(s) as directed in the diabetes health care plan.	

Halifax Regional School Board IN PARTNERSHIP WITH IWK Health Centre

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.

SYMPTOMS

Frequent urination	Blurred Vision
Hungry	Thirsty
Nausea	Vomiting
Abdominal pain	Other:

ACTION

Steps In Order:

1. Instruct student to test blood sugar with glucometer if able. Supervise this action. Blood sugar may need to be obtained by support person.

2. Call parent(s)/guardian(s) if blood sugar level is greater than or equal to:_____

3. If the student is feeling well, and the blood sugar level is below _____, no immediate treatment is required.

   Allow the student to resume activity as normal.
   Allow the student to eat usual meal or snack.
   Allow the student to access the washroom as necessary; the student will be thirsty and need to urinate frequently.

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.

EMERGENCY CONTACTS

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

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 herby 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): _____

Halifax Regional School Board IN PARTNERSHIP WITH IWK Health Centre

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 ☐ NO ☐			
MedicAlert® Number:			
Rescue Medication Ordered: YES ☐ NO ☐ *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 ☐ NO ☐ *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

☐ Sudden cry or moan ☐ Cyanosis (skin color turns blue) ☐ Choking or gurgling
☐ Stiffness (tonic) ☐ Rhythmic muscle jerks (clonic) ☐ Loss of bladder or bowel control
☐ Bite tongue or cheek ☐ Fall with no warning
☐ Shallow or temporary cessation of respirations

☐ 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.

CONSENT

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.				

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 herby consent for my child to be transported to a hospital if required, based on the judgment 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):_____

Halifax Regional School Board IN PARTNERSHIP WITH IWK Health Centre

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

Asthma Health Care Plan: Management and Emergency Procedures

IDENTIFICATION

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 ☐ NO ☐		
MedicAlert® Number (if applicable):		
Time of year your child's asthma is most active: ☐ Spring ☐ Fall ☐ Year round ☐ Summer ☐ Winter		

Please check asthma triggers for your child:

☐ Animal allergy ☐ Exercise ☐ Pollen ☐ Other (please specify):
☐ Cold ☐ Mold ☐ Scents

Please check the prescribed reliever medication (medicine used during a flare-up): ☐ Ventolin ☐ Bricanyl ☐ Other (please specify):	Please check the device to be used with the reliever medication: ☐ Spacer with a facemask ☐ Spacer with a mouthpiece ☐ Aerosol compressor ☐ Diskus ☐ 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:

	Additional Information:

	Trained school staff in this student's asthma care:*for office use. 1. 2. 3.
	Plan effective on: (insert date)

Definition of asthma:
A chronic lung condition where inflammation of the airways causes a cough, wheeze, chest tightness or shortness of breath.

SYMPTOMS	Please check your child's asthma symptoms: ☐ Cough ☐ Shortness of breath ☐ Other (please specify): ☐ Wheeze ☐ Chest tightness
NOTIFICATION	Please specify if and how you would like to be notified when your child experiences asthma symptoms during school:

FLARE-UP

Recognizing a Flare-Up of Asthma Symptoms

- Faster breathing
- Persistent cough
- Wheezing (a high pitched musical sound when breathing)
- Complaint of chest feeling tight
- Shortness of breath at rest or when talking (can only say 3-5 words between breaths)
- The skin is "sucked in" with each breath at the neck and/or around the collar bone
- Cough, wheeze or chest tightness during or following exercise
- Other symptoms you may notice during a flare-up specific to my child (please list):

ACTION

Steps in Order:

1. Have the student sit down to rest. DO NOT lay the student down.
2. Speak calmly and do not panic. Keep the student calm using techniques specified by the parent(s)/guardian(s).
3. Administer a dose of the reliever medicine. Name the medicine and the dose:
4. Tell the student to take slow, deep breaths.
5. Monitor the student for 5-10 minutes.

   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)

   IF SYMPTOMS REMAIN THE SAME OR WORSEN FOLLOW STEPS 6-7

6. Administer a second dose of the reliever medication. Name the medication and dose:
7. Monitor the student for 5-10 minutes.

   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)

   IF SYMPTOMS REMAIN THE SAME OR WORSE, CALL 9-1-1 (unless otherwise indicated in the notification section) AND FOLLOW STEPS 8-10

8. Administer the prescribed reliever medication as often as needed until EHS and/or the parent(s)/guardian(s) arrives.
9. Stay with the student until EHS and/or the parent(s)/guardian(s) arrives.
10. Call the parent(s)/guardian(s) if not previously notified.

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

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

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 herby 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): _____

Halifax Regional School Board IN PARTNERSHIP WITH IWK Health Centre

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

General Health Care Plan: Management and Emergency Procedures

IDENTIFICATION

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 ☐ NO ☐			
Wears MedicAlert®: YES ☐ NO ☐			
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) ☐ Other ☐ (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.

	First Scenario	**Second Scenario**	**Third Scenario**
SYMPTOMS, WARNING SIGNS AND/OR CONCERNS			
ACTION	**Steps in Order:**	**Steps in Order:**	**Steps in Order:**

CONSENT

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.				

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 herby 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): _____

Halifax Regional School Board IN PARTNERSHIP WITH IWK Health Centre

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

Tube Feeding Procedure Plan

IDENTIFICATION

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			
Special Patient Protocol: YES ☐ NO ☐			
MedicAlert® Number:			
Can take food by mouth: YES ☐ NO ☐			
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)			

BOLUS FEEDS

***Students who require bolus feeds during school hours** (a specific volume delivered at specific times throughout the day)

Describe how to give the feed:

Tube feeding time(s) during school hours	Volume of formula	Length of time to give the feed over
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:			
CONTINOUS	***Students who require continuous feeds during school hours**			
	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:			
	Gastrostomy Feeding Tube (GT): A tube that passes through the abdomen (belly wall) into the stomach. **Jejunostomy Feeding Tube (JT): A tube that passes through the abdomen (belly wall) into the small bowel.** ***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.**			
CONCERNS	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
ACTION	**Steps in Order:** **1.** Stop the feed. **2.** Clamp the tubing. **3.** Check the rate and amount of feed left to be administered. **4.** Call the parent(s)/guardian(s) if there are discrepancies or the student does not stop vomiting. Note: If the feed is going too fast, especially in the jejunum, it may cause vomiting, diarrhea, cramps, sweating and/or fainting.	**Steps in Order:** **1.** Stop the feed. **2.** Clamp the tubing. **3.** Disconnect the feed, keeping both ends clean. **4.** Elevate the end of the GT. **5.** Open the end of the tube to allow air to escape (this is called "venting"). **6.** Re-connect tubing to the student when symptoms are relieved. Unclamp tubing and re-start the feed as ordered by the parent.	**Steps in Order:** **1.** Check to see if the tube is kinked. **2.** Reposition the tubing. **3.** If problem persists, clamp the tubing. **4.** Disconnect the tube from the student, keeping both ends clean and flush with water as directed to clear any blockage. **5.** Re-prime the tubing with the formula, unclamp the tubing and re-start the feed as ordered by the parent(s)/guardian(s).	**Steps in Order:** **1.** Place a clean folded towel over the stoma (opening in the skin). **2.** Call the parent(s)/guardian(s). **3.** If the parent(s)/guardian(s) cannot be reached, take the following action: _____ _____ _____

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

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 herby 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 Procedure 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 Procedure 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): _____

Halifax Regional School Board IN PARTNERSHIP WITH IWK Health Centre

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

Catheterization Procedure Plan

IDENTIFICATION

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 ☐ NO ☐			
MedicAlert® Number (if applicable):			
List time(s) the child requires catheterization during school hours:			
Child can self-catheterize without supervision ☐ Child can self-catheterize but requires supervision ☐ Child requires a school staff member perform the catheterization(s) ☐			
Child requires catheterization through: the urethra ☐ a stoma ☐			

Supplies required:

1. Soap and water or antiseptic hand wash for the staff member
2. Gloves
3. Cleansing items for the child: wipes or washcloth, soap and water
4. Catheter please specify size
5. Lubricant
6. Container to train the urine if not on the toilet
7. Diaper or pad if required
8. Other (please specify if necessary):

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.

CATHETERIZATION VIA URETHRA

***Students who require clean intermittent catheterization through the urethra**

Steps to Clean Intermittent Catheterization

1. Wash hands and put on gloves
2. Wash the perineal area

   Note: to cleanse, wipe three times: left side, right side, middle
3. Lubricate the first two inches of the catheter
4. Insert the catheter (see below)
5. Drain the urine
6. Withdraw the catheter slowly
7. Wash the catheter and hands together with soap and water
8. Rinse the catheter
9. Allow the catheter to air dry
10. Store the catheter in a Zip-lock bag
11. Store the catheter in a dry place

Please describe the process of inserting the catheter in your child's urethra:

CATHETERIZATION VIA STOMA

***Students who require clean intermittent catheterization through a stoma**

Steps to Catheterizing through a Stoma

1. Wash hands and put on gloves
2. Clean the stoma site
3. Lubricate the first two inches of the catheter
4. Insert the catheter in the stoma (see below)
5. Drain the urine
6. Withdraw the catheter slowly
7. Wash the catheter and hands together with soap and water
8. Rinse the catheter
9. Allow the catheter to air dry

10. Store the catheter in a Zip-lock bag
11. Store the catheter in a dry place

Please describe the process of inserting the catheter in your child's stoma:

SYMPTOMS

Please check symptoms that would require a staff person to notify parent(s)/guardian(s). If another action is preferred, please indicate.

☐ Unusual pain in back or belly ☐ Fever ☐ Blood in the urine

☐ Foul smelling urine ☐ Nausea and/or vomiting ☐ Other:

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.

	First Scenario:	**Second Scenario:**	**Third Scenario:**
CONCERNS			
ACTION	**Steps in Order:**	**Steps in Order:**	**Steps in Order:**

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

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 herby 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 Procedure 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 Procedure 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): _____

Medical Procedures Tracking Form (Sample)
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