Appendix 1: Life Threatening Medical Condition PLAN of CARE

The collection, use and disclosure and retention of personal information including personal health information is pursuant to the *Municipal Freedom of Information and Protection of Privacy Act*, RS) 1990, c.M.56, and *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Sched. A and shall be used for the purpose of implementing a Plan of Care in accordance with the *Education Act* RSO, 1990

Please ensure that this form is filled out legibly and kept up-to-date

School Name: _____

Student Name: _____

Student Number: _____ **Grade:**_____

Parent(s)/Guardians: _____ _____

Civic Address: _____

_____

Home Phone Number: _____ **Cell Phone Number:**_____

I/we authorize this PLAN OF CARE to be shared with school staff, occasional staff, volunteers, and disclosed to bus contractors, bus drivers and Student Transportation of Eastern Ontario (STEO), for the purpose of implementing my child's Plan of Care. I agree that the school may post my child's picture and implement emergency measures as outliined.

Parent's/Guardian'sSignature:_____**Date:**_____

☐ **I consent to information about my child's medical condition being shared with students to assist in the education and monitoring of my child's condition.**

Parent's/Guardian's Signature:_____ **Date:**_____

☐ **I do NOT consent to information about my child's medical condition being shared with students to assist in the education and monitoring of my child's condition.**

Parent's/Guardian's Signature:_____ **Date:**_____

Implementation of Plan of Care:

A copy of the Plan of Care can be located in the School Office. Emergency Protocols for the Plan of Care shall be posted as indicated below:

- ☐ school office
- ☐ staff room
- ☐ gymnasium hallway
- ☐ classroom/homeroom
- ☐ cafeteria

Consultation and a review of the Plan of Care took place with the parent/guardian and student (as appropriate) on:
Date:_____

Review of the Plan of Care took place with the homeroom/classroom teacher school, staff, and volunteers:
Date:_____

Review of the Plan of Care took place with and transportation provider on:
Date: _____

Plan of Care must be reviewed on or before:
Date:_____

Principal's Signature: _____ Date:_____

Appendix 1: LIFE THREATENING MEDICAL CONDITION PLAN of CARE

STUDENT: _____ CLASSROOM/HOMEROOM TEACHER: _____

PLEASE DESCRIBE CONDITION:_____

TRIGGER AVOIDANCE PROTOCOL (if applicable):

REGULAR MEDICATION & DOSAGE (if applicable):

EMERGENCY RESPONSE Plan:

LOCATION OF POSTING:
Plan of Care in classroom(s)_____

EMERGENCY PROTOCOL shall be posted _____

STUDENT FILE:
Location of student's Life Threatening Medical Condition Plan of Care and supporting documents shall be located in the office area and accessible to the principal/designated. Once student is no longer attending the School, the file shall be confidentially disposed.

Appendix 1:

LIFE THREATENING MEDICAL CONDITION PLAN of CARE – EMERGENCY CONTACT SHEET

Parent/Guardian/Emergency Contacts (Prioritize calls #1, #2, #3, …)

	First Name	Last Name	Relationship	Home	Work	Cell #
1						
2						
3						

Appendix 2: EMERGENCY PROTOCOL PLAN OF CARE
LIFE THREATENING MEDICAL CONDITION EMERGENCY

Insert Student Photo here

Student Name: _____ _____
Last Name First Name

Classroom/Homeroom Teacher(s) _____

Child Wears Medical Bracelet: ☐ YES ☐ NO

Possible Triggers and Inducers - List those below that apply:

Student Information

This child experiences_____

The actions to be taken when this child has an life threatening medical emergency are [INSERT Description]

Student may require administration of medication if:

_____
_____
_____
_____
_____

WHEN TO CALL 911

If the student exhibits any of these symptoms

(Please specify):

_____
_____
_____
_____
_____
_____
_____
_____

Monitor until Emergency Services Personnel Arrive
Staff attendance with student to hospital
Communication with parent/guardian or emergency contact

Date: _____ **Parent/Guardian Signature:** _____

Appendix 3:

TRANSPORTATION GUIDELINES for LIFE THREATENING MEDICAL CONDITION PLAN OF CARE

The Upper Canada District School Board (UCDSB) and the Student Transportation of Eastern Ontario (STEO) recognizes the possible need for assistance by school bus drivers to identified students living with a life threatening medical condition(s):

1. When a student has been identified as having a life threatening medical condition, schools/principals shall:
    a. Submit three (3) copies of STEO Life Threatening Emergency Medical Form, for those students being transported by the Student Transportation of Eastern Ontario (STEO), to the Student Transportation of Eastern Ontario within ten school days from the start of each school year; and
    b. Resubmit three (3) copies of STEO Life Threatening Emergency Medical Form if there is a change in the student's bus route number.

2. At the beginning of each school year bus drivers will be invited and encouraged to attend the staff training sessions for life threatening medical condition.

3. The General Manager (or designate) of the Student Transportation of Eastern Ontario (STEO) will annually identify, by bus route number and school, students with life threatening medical condition.

4. If a replacement driver operates a route carrying an identified student with life threatening medical condition, or any other life-threatening medical condition that has been documented on a STEO Life-Threatening Emergency Medical Form, the dispatcher must ensure that the replacement driver is aware of the student.

5. Students should be advised not to consume food on the bus, unless pursuant to an accommodation plan.

6. If an identified student living with life threatening medical condition appears to be showing symptoms of condition:

a) The school bus driver should:
    a. Secure the vehicle
    b. Secure the passengers
    c. Assist the student living with life threatening medical condition to remain safe;
    d. Notify the dispatcher of the need for additional assistance;
    e. Monitor student and await the arrival of emergency response personnel;
    f. Complete and submit a report to Student Transportation of Eastern Ontario detailing the incident.

b) The dispatcher should:
    a. Confirm with the school bus driver the location and time of the incident
    b. Advise Emergency 911, the school principal and the General Manager (or designate) of Student Transportation of Eastern Ontario (STEO) of the incident;
    c. Remain in constant contact with Emergency 911 personnel and the school bus driver.

c) The school principal/designate should:
    a. Contact the student's parent/guardian/emergency contact

Appendix 4

UPPER CANADA DISTRICT SCHOOL BOARD

Consent to Obtain and/or Release Information

The collection, use and disclosure and retention of personal information including personal health information is pursuant to the *Municipal Freedom of Information and Protection of Privacy Act*, RS) 1990, c.M.56, and *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, Sched. A and shall be used for the purpose of implementing a Plan of Care in accordance with the *Education Act* RSO, 1990, c.E.2 and PPM 161 Prevalent Medical Conditions.

Student Name: _____	D.O.B. (mm/dd/yy): _____/_____/_____
School: _____	Student ID: _____

I, _____, give my consent for the following person/agency:

Name of Person/Agency: _____

Street Address: _____

City/Prov./Postal Code: _____

Phone Number: _____

To obtain (specify information) _____

FROM:

Name of Person/Agency: _____

Street Address: _____

City/Prov./Postal Code: _____

Phone Number: _____

To release (specify information)_____

TO:

Name of Person/Agency: _____

Street Address: _____

City/Prov./Postal Code: _____

Phone Number: _____

I understand:

a. the period of consent will terminate one year from the date it was granted as indicated below;
b. the nature and purpose for which this information is being obtained/released/exchanged;
c. this information will be used for the planning and provision of educational services;
d. that I may revoke my consent at any time;
e. this information will be treated confidentiality;
f. that a copy of all information will be made for the confidential files at the UCDSB regional office.
g. this information will be placed in the OSR. My initials here _____ indicate that consent for this is NOT given.

Signature: _____ Relationship to Student: _____

Phone #: _____ Date:_____