OTTAWA-CARLETON
DISTRICT SCHOOL BOARD

OCDSB 963: PLAN OF CARE FOR STUDENTS WITH OTHER LIFE THREATENING MEDICAL CONDITION(S) FORM

(References: **P.108.SCO**, **PR.548.SCO**, and **PR.547.SCO**)

The information on this form is collected annually and deemed valid until August 31 of each school year.

- Student Name (first, middle, last):
- Student Date of Birth:
- School Name:
- Grade:
- Student Number:
- Teacher Name:

Parent/Guardian Information (required if student is under 18 years of age)

- Parent/Guardian First and Last Name :
- Home Phone Number:
- Parent Email Address:

Emergency Contacts (Please list in order of priority)

Name	Relationship	Daytime Phone	Alternate Phone	Email
1.				
2.				
3.				

Primary Healthcare Provider Information

- Name:
- Telephone number:
- Profession/Role:

Student Medical Information

Please specify the medical condition:

Healthcare Specialist Information

Healthcare Specialist

- (•) Same as Primary Healthcare Provider.
- ( ) Different from Primary Healthcare Provider (Complete the following information)

Name:

Telephone:

Profession/Role:

- ( ) Certified Asthma Educator
- ( ) Certified Respiratory Educator
- ( ) Nurse Practitioner
- (•) Pharmacist
- ( ) Physician
- ( ) Registered Nurse
- ( ) Respiratory Therapist
- ( ) Other. Please specify:

[ ] I/We authorize the school staff to contact the above health care provider as required to attend to the well-being of the student.

Please upload the most recent, original instructions, prescriptions, and labels pertaining to each medication. Date of prescription/notes must be captured.

Daily Management and Emergency Procedures

[ ] I/We authorize the school staff to contact the above health care provider as required to attend to the well-being of the student.

Please upload the most recent, original instructions, prescriptions, and labels pertaining to each medication. Date of prescription/notes must be captured.

Daily Management and Emergency Procedures

Triggers:

Avoidance Strategies and Safety Measures:

Symptoms and Warning Signs:

Course of Action:

Other Required Accommodation: (e.g. during nutrition breaks, field trips)

Other Comments:

Medication

Does prescribed medication have to be administered during school hours?

- ○ Yes.
- ◉ No. Please proceed to "Consent to Release Information".

Name of medication:

Dosage of Medication:

Time of Medication:

Special Instructions for Administration:

Duration of Medication Regime:

Caution of Notable Side Effects:

Do you authorize the student to carry required medication and delivery devices at all times?

- ○ Yes. Please specify below.
- ◉ No. Please specify below.

Please specify (eg. name of individual or locker number):

Please specify location of backup medication in school:

Storage Cautions (if any):

Disposal Instructions:

☐ I/We acknowledge that it is my/our responsibility to submit enough backup medication and medical supplies to school and to track the expiration date.

Parent(s)/Guardian(s) Authorization to Administer Medication

☐ The administration of medication involves certain elements of risk, including, but not limited to illness, adverse reactions or other complications. Reactions caused by the administration of any medication can occur without fault on any party; the student, or the OCDSB or its employees or agents. By requesting and consenting to the administration of medication by an employee of the OCDSB, or by authorizing the self-administration of medication by the student, you are assuming any associated risks.

In life-threatening emergencies, staff will administer prescribed medication to students “in loco parentis” and not as healthcare professionals

☐ I/We authorize the OCDSB staff to administer prescribed medication to the student as prescribed. I/We understand that OCDSB staff is not medically trained to administer medication and bear sole responsibility for any adverse reaction that might occur following the administration of medication.

☐ The student is capable of administering their own medication. I/We bear sole responsibility for any adverse reaction that might occur following the self-administration of medication.

Consent to Release Information

Does the student use OSTA bus on a regular basis?

- ○ Yes. A copy of the Student Care Plan will be shared with OSTA.
- ◉ No.

☐ I/We give consent for the school to share this Plan of Care as necessary with individuals in direct contact with the student to attend to their well-being and medical needs at school and during school activities. This may include school and office staff, occasional staff, OSTA, contracted bus operators and bus drivers, before- and after-school program staff. This plan will be posted in identified areas of the school for emergency response purposes.

Parent(s)/guardian(s) signature (if student is under 18 years of age):

Adult student signature: _____

Date: _____

The personal information of this form is collected under the authority of the Education Act (RSO. 1990 c.E.2) and in accordance with the Municipal Freedom of Information and Protection of Privacy Act (RSO. 1990 c.M56), as amended. It will be used to establish the Ontario Student Record [OSR] and for student and education related purposes such as registration, administration, communication, collection of fees, data reporting, and Student Transportation Services. In addition, the information may be used or disclosed to comply with legislation, for compelling circumstances affecting health and safety or discipline, as required in circumstances related to allow enforcement matters, and with third parties in accordance with established service agreements or in accordance with any other Act. Questions or concerns should be directed to the school principal or the Board's Freedom of Information Coordinator, Ottawa-Carleton District School Board, 133 Greenbank Road, Ottawa, Ontario, K2H 6L3, Telephone 613-596-8211 ext. 8607.