PROCEDURE SO102

Request for School Assistance in Health Care

Board Received: September 26, 2016 **Review Date:** October 2020

Accountability:

1. Frequency of Reports – As needed
2. Criteria for Success – Proper forms updated and completed accurately.
   – Proper training and guidance from Regional Health Unit.
   – Clear communications with parents/guardians and employees.

Procedures:

As a general rule teaching personnel should not become involved with the administration of medication to, and/or the performance of physical procedures for pupils because such matters are primarily the responsibility of pupils' parents or guardians, in conjunction with trained medical personnel.

This recognizes, however, through the Ontario Ministry of Education and Training Policy Memorandum 81, that there will sometimes be the need for school staff to administer medication to pupils and/or to perform physical procedures for them during the school day in order to enable the education of such pupils to continue, or in emergency situations. The following procedure outlines the conditions under which the administration of medication to and/or performance of physical procedures for pupils by school personnel may be carried out.

1. No teacher or principal employed by the Board is required to administer medication to, and/or perform physical procedures for a pupil. However, in an emergency situation all employees may have to administer first aid, which may include auto-injector or inhalers because of the life threatening nature of the incident. See Policy30 – Management of Potentially Life-Threatening Health Conditions in Schools.)

2. A "Request for School Assistance in Health Care" form shall be sent home to be completed and forwarded to the principal of the school (to be housed in the Ontario Student Record) prior to the administration of any medication by school personnel. Communication verbally with parent/guardian will occur when the form is sent home in order to build collaborative and productive relationships that will enhance understanding of the specific health concerns of the student and to ensure that the parent/guardian understands the expectations outlined in the form.

3. A "Student Support Plan for School" and a "Student Support Plan for Transportation" shall be completed on LITE printed and copied for the parent/guardian to sign, and then housed in the Ontario Student Record.

4. A revised Request for School Assistance in Health Care form shall be completed by the parents or guardians and forwarded to the principal for each school year, or whenever a modification of the prescribed medication is directed by the physician. The revised authorization form must be received prior to medication being administered.

5. The principal shall maintain a current list of all pupils receiving medication. Such list may be shared with the local Health Unit with the consent of the pupil's parents.

6. Parents are responsible to ensure that the school is advised of any changes in medication. Each parent shall be responsible for the delivery of prescribed medication to the principal (or designate) at intervals as may be determined by the parents and/or physician, and the principal (or designate) shall deliver to the parents any unused medication at the end of the school year or other times as determined by the parents and/or physician.

7. A staff person volunteering to administer medication to a pupil shall give consent to such administration by signing the Supervision section of the Request for School Assistance in Health Care form. Where a staff person agrees to supervise the self-administration of medication by a pupil, the staff person shall give consent to such supervision by signing the Supervision section of the Request for School Assistance in Health Care form.

8. The staff person shall maintain the "Student Medication Record" which includes both administration and self-administration of medication. On dates when the pupil is absent, the log should reflect such pupil absence. The "Comments" section should reflect abnormal or unusual circumstances related to such administration. The monthly log sheet is to be filed in the Ontario Student Record by the principal with the signed authorization form.

9. Medication will be administered in a manner which allows for sensitivity, privacy and dignity of the student, while also encouraging the student to take as much responsibility for his/her own medication as is appropriate.

10. Assistance in training to administer medication is the responsibility of the parents, in conjunction with the principal. Parent/guardian should seek advice from the physician or the Health Unit.

11. The principal should ensure that medication:
    a) is clearly labelled for each pupil;
    b) has clearly indicated dosage; and
    c) is securely stored to ensure administration to the correct child, and to avoid loss or tampering.

12. Non–health care professionals are not authorized to administer injections; therefore, requests made by parents in relation to administering injections shall be denied. The exemption is when administering auto-injectors for anaphylaxis in an emergency situation.

13. It is understood that the staff person is administering medication under the principle of "in loco parentis", and not as a health professional.

14. Personal assistance for pupils with physical disabilities such as lifting, toileting, feeding, catheterization, etc. shall not be the responsibility of the teacher in charge of the pupil. Personal assistance support may be carried out by non-teaching personnel assigned such responsibility by the principal supported by the recommendations of health care providers

GRAND ERIE DISTRICT SCHOOL BOARD

REQUEST FOR SCHOOL ASSISTANCE IN HEALTH CARE - Appendix A

STUDENT INFORMATION:

NAME: _____ D.O.B._____ Current Age: _____
Surname Given Name YYYY / MM / DD years/ months

Address: _____ Telephone:_____
(Street/ Lot/ Con./ Town/ Postal Code)

School:_____ Grade:_____ Principal:_____

Parent/Guardian:_____
(Mr./ Mrs./ Ms./ Miss/ Mr. & Mrs.) (Surname / Given Name)

TYPE OF HEALTH CARE ASSISTANCE

☐ Administration of Prescribed Medication

☐ Supervision of Student's self-administration of prescribed medication

TYPE		SCHEDULE	
☐ Oral	☐ Auto-Injected	☐ Short-Term (specify _____)	☐ Emergency
☐ Inhaled	☐ Other (specify_____)	☐ Trial (specify_____)	☐ 2nd treatment available (see Physician's statement)
☐ External		☐ on-going	

Other (specify) _____

Expiry date for medication, if applicable: _____

Child wears MedicAlert™, if applicable: ☐ bracelet ☐necklace

ANAPHYLAXIS

_____ (Student Name) is identified to have possible life threatening allergic reactions to the following and requires the use of medication to manage his/her symptoms:

Triggers: i.e. foods, insect sting	Symptoms: i.e. Itching, Hives	Treatment: i.e. Auto-Injector

Medical Certification

This is to certify that _____(Student Name) has Anaphylactic Allergic Reactions and uses the following medication:

Doctor's Name:_____Telephone: _____

Doctor's Signature_____Date _____
YYYY / MM / DD

Medication	Dosage	Frequency
☐	☐	☐
☐	☐	☐

ASTHMA

_____(Student Name) is identified to have symptoms of asthma and requires the use of medications to manage his/her symptoms:

Triggers: i.e. colds, exertion	Symptoms: i.e. cough, wheezing	Treatment: i.e. Inhaler

Medical Certification

This is to certify that _____(Student Name) has Asthma and uses the following medication:
Doctor's Name:_____Telephone: _____

Doctor's Signature_____Date _____
YYYY / MM / DD

Medication	Dosage	Frequency
☐	☐	☐
☐	☐	☐

DIABETES

_____ (Student Name) is identified to have symptoms of diabetes and requires the use of medication to manage his/her symptoms:

Triggers: i.e. not eating, tired	Symptoms: i.e. sweating, hunger	Treatment: i.e. juice

Medical Certification

This is to certify that _____(Student Name) has Type 1 Diabetes and uses the following medication:

Doctor's Name:_____Telephone: _____

Doctor's Signature_____Date _____
YYYY / MM / DD

Medication	Dosage	Frequency
☐	☐	☐
☐	☐	☐

SEIZURE DISORDER

_____ (Student Name) is identified to have a seizure disorder and requires the use of medication to manage his/her symptoms:

Triggers: i.e. dehydration, flashes	Symptoms: i.e. stare, twitching	Treatment: i.e. clear sharp objects/furniture, turn on side

Medical Certification

This is to certify that _____has a seizure disorder and uses the following medication:

Doctor's Name:_____Telephone: _____

Doctor's Signature_____Date _____
YYYY / MM / DD

Medication	Dosage	Frequency
☐	☐	☐
☐	☐	☐

A new authorization form must be submitted each school year and whenever the medication(s)/procedures(s) is modified. This form must be retained in the school for one year after termination of medication/procedure. It is understood that the staff person is administering medication or providing service under the principle of "in loco parentis", and not as a health professional.

In the event that a "physician's statement" does not accompany the Request for School Assistance in Health Care, The Grand Erie District School Board assumes no responsibility for the administration of medication or the self-administration of medication by students. Principals are to advise a parent, requesting school assistance in health care without a physician's statement, of this in writing.

PHYSICIAN'S STATEMENT FOR HEALTH CARE ASSISTANCE DURING SCHOOL HOURS

In my opinion, the following procedures are medically appropriate for the above-named student and should be administered during the school day:

1. Name of procedure(s) or medication(s):
   _____
   _____

2. Administration during school day: ☐ _____a.m. ☐ _____p.m.

3. Administration/procedure required for: ☐ _____days ☐ remainder of school year
   ☐ emergency only
   ☐ 2nd treatment recommended if medical help unavailable within _____ minutes

Name of Physician:_____Telephone:_____

Signature of Physician:_____

PARENT/GUARDIAN APPROVAL:

I hereby authorize and request the administration of the above medication(s)/procedure(s) for the above-named child in the manner and duration stated by the physician. I will provide the medication to the school in a container clearly labeled by a pharmacist and give any necessary instruction as to the storage of same medication.

In regards to the management of ANAPHYLAXIS, I/We are responsible for ensuring that:

- The school is supplied with up-to-date injection kits that are kept current two (2) if possible, one to be kept with the student and one to be kept in a secure location in the school)
- We have informed the school that for incidents relating to the anaphylaxis I/we wish to be contacted regarding the following type(s) of incident(s):
- Parent/guardian initial: _____

In regards to the management of ASTHMA, I/We are responsible for ensuring that:

- The school is provided with a minimum of one (1) up-to-date inhaler properly marked with the child's name and expiry date (a second if possible, to be kept in a secure location in the school)
- We have informed the school that for incidents relating to the asthma I/we wish to be contacted regarding the following type(s) of incident(s):
- Parent/guardian initial: _____

In regards to the management of **DIABETES**, I/We are responsible for ensuring that:

- there is a supply of fast acting sugar (oral glucose/orange juice etc.) at the school
- blood glucose monitoring items are contained in a safe container, labelled with my child's name, for transport and storage in class
- Insulin injection items are contained in a safe container, labelled with my child's name.
- An approved sharp disposal unit and the collection and disposal of used sharps.
- We have informed the school that for incidents relating to the diabetes I/we wish to be contacted regarding the following type(s) of incident(s):
- Parent/guardian initial: _____

In regards to the management of **SEIZURE DISORDER**, I/We are responsible for ensuring that:

- The school is provided with a minimum of one (1) up-to-date medication package (if applicable) properly marked with the child's name and expiry date
- We have informed the school that for incidents relating to the seizure disorder I/we wish to be contacted regarding the following type(s) of incident(s):
- Parent/guardian initial: _____

In consideration for exercising the method of administration of the medication as indicated above, the Grand Erie District School Board and its employees, contract workers and volunteers are hereby released and forever discharged from any and all liabilities, covenants, claims, actions and damages arising as a result of exercising such procedure.

I hereby further agree to indemnify and save harmless, the Grand Erie District School Board and its employees, contract workers and volunteers from and against any loss, damage, claim or expense suffered or incurred by them as a result of exercising the method of administration as outlined above.

Parent/Guardian Signature:_____ Date:_____

SUPERVISION:

Person(s) designated to supervise/administer medication(s)/procedure(s) and to maintain record:

Name: _____ Alternate:_____
(Signature) (Signature)

Alternate: _____ Alternate:_____
(Signature) (Signature)

Principal's Signature:_____ Date:_____

NOTICE:

Authorization for the collection and maintenance of the personal information recorded on this form is the Education Act, R.S.O. 1980, S.265(d) and S.266 and the Municipal Freedom of Information and Protection of Privacy Act. Users of this information are supervisory officers, principals and teachers at the school. Any questions regarding the collection of personal information should be directed to the principal of the school.

I/We hereby consent to the use of personal information contained herein by the persons above-named and by such other officers or employees of the Board who may need the personal information in the performance of their duties as employees of the Grand Erie District School Board.

Signature of Parent/Guardian: _____ Date: _____

Distribution: O.S.R.
School Office

THE GRAND ERIE DISTRICT SCHOOL BOARD

STUDENT MEDICATION RECORD - Appendix B

☐ Administered ☐ Self-Administered

Name of Student:_____ Date of Birth:_____

Address:_____ Telephone:_____

School:_____ Principal:_____

DATE	TIME	MEDICATION/ DOSAGE	COMMENT	SIGNATURE OF PERSON ADMINISTERING / SUPERVISING	SIGNATURE OF WITNESS

Original -- O.S.R.

NOTE: This record must be retained in the O.S.R. with the "Request for School Assistance in Health Care" form for one year after termination of medication.