OTTAWA-CARLETON
DISTRICT SCHOOL BOARD

PROCEDURE PR.547.SCO

TITLE: ADMINISTERING MEDICATION TO STUDENTS

Date issued: 18 June 1998
Last revised: 26 November 2013
Authorization: Senior Staff: 18 June 1998

1.0 OBJECTIVE

To provide guidelines for the administration of prescribed medication to students during school hours, and during an approved school activity, and to minimize the risk of potentially fatal reactions due to severe and life-threatening allergies or symptoms which present from other serious medical conditions.

2.0 DEFINITIONS

In this procedure,

2.1 **Available staff** means staff members who are accessible and able to carry out necessary procedures.

3.0 RESPONSIBILITY

3.1 The school principal

4.0 PROCEDURES

4.1 When a request for the administration of oral medication is received from the parent or guardian of a student under 18 years of age, or from a student 18 years of age or over, the principal will obtain a Request Form OCDSB 286: Administration of Oral Medication or OCDSB 285: Self-Administration of Oral Medication, signed by the parent/ guardian if a student is under 18, or by the student if 18 years of age or over, and by the supervising physician, indicating the type of medication to be administered, the required dosage, and the action to be taken in the event of possible hazards or side-effects. In the event of any change in medication, a new form must be completed prior to administration. The original copy of these forms will be kept on file in a secure location in the school office, with copies going to the parent or guardian and the OSR. The consent forms lapse as of June 30 of any school year, but for insurance purposes are to be retained until the end of the school year following the year for which consent was given.

4.2 A record of the administration of prescribed medication will be retained in the school office on Form OCDSB 287: Student Medication Log.

4.3 Parents / guardians who authorize release of relevant information to those who may be involved in the care of a student with a serious medical condition will be required by the Principal to complete OCDSB 802: Serious Medical Conditions Protocol Registration Form. The original copy of these forms will be kept on file in a secure location in the school office, with copies going to the parent or guardian, and the OSR. The information on these forms will lapse as of 30 June of any school year following the year for which consent was given.

a) For students being transported, the principal is responsible for the submission of three copies of the OSTA Life-Threatening Medical Conditions Emergency Transportation Form to the General Manager (or designate) of the Ottawa Student Transportation Authority within 10 school days from the start of each school year.

b) For students being transported, the principal is responsible for the submission of three copies of the OSTA Life-Threatening Medical Conditions Emergency Transportation Form to the General Manager (or designate) of the Ottawa Student Transportation Authority within 10 school days from the start of each school year.

c) Serious Medical Conditions are defined in OCDSB Policy P.108.SCO Care of Students with Life-Threatening Medical Conditions.

4.4 A staff member administering oral medication or an epinephrine auto injector *(i.e.:EpiPen*® or *Allerject™)* is acting according to the principle "*in loco parentis*", not as a health care professional, and is covered by the OCDSB's liability insurance.

4.5 The principal or designate will arrange a briefing for one or more staff members and alternates regarding the administration of the prescribed medication and its safekeeping. The alternate or alternates will administer the medication in the absence of the regularly designated responsible staff member. In the absence of the designate(s) and alternate(s) in an emergency situation, an available staff member will administer prescribed medication.

4.6 Wherever feasible and authorized by the principal on Form OCDSB 405: Emergency Use of an Auto injector, OCDSB 286: Administration of Oral Medication Authorization, or OCDSB 285: Self-Administration of Oral Medication Authorization, the student or the student's parent or guardian may accept the responsibility for administering prescribed medication during school hours.

4.7 All medication must be kept in a secure location with provision being made for responsible individuals to have access to it as required. In some cases (e.g., "Ventolin" inhalers, Cotazyme E.C.S.), students may be authorized to carry their own medication, provided the principal is satisfied that:

a) the parents/guardians, or the student if over 18 years of age, and physician have authorized self-administration on Form OCDSB 285: Self-Administration of Oral Medication Authorization;

b) the student has been trained in the proper administration of the medication; and

c) there is no evidence that the student is abusing the responsibility.

4.8 Prescribed medication will be administered with sensitivity and in privacy, and so as to encourage the student to take an appropriate level of responsibility for his or her medication.

4.9 All prescribed oral medications should be transported to and from school in a child-proof container which is clearly labelled with the student's name, the medication, and dosage. If the medication is to be given by school staff, the medication will be provided in the original pharmaceutical container with label.

Use of an Epinephrine Auto injector (i.e.: *EpiPen*® or *Allerject*™*).*

4.10 The Ottawa-Carleton District School Board (OCDSB) and Ottawa Public Health (OPH) only support the use of epinephrine auto injectors.

4.11 When a request for the use of an auto injector in the event of an emergency is received from the parent or guardian of a student under 18 years of age, the principal will obtain a signed OCDSB 405: Emergency Use of the Auto Injector Authorization from the parent or guardian and supervising physician. Parents/guardians are responsible for providing two current-dated auto injectors per student.

4.12 The principal will contact the Ottawa Public Health staff assigned to their school in order to arrange an instructional session on anaphylaxis prevention and to familiarize school staff with the use of the auto injectors.

4.13 In a case where there is any suspicion that the student may have been exposed to his/her life-threatening allergen or is displaying symptoms identified on Form OCDSB 616: Severe and Life-Threatening Allergy Protocol, the principal or designate or available staff member will administer epinephrine by means of an auto injector in accordance with the courses of action identified on completed form OCDSB 616: Severe and Life-Threatening Allergy Protocol.

4.14 The principal or designate will call 911 and make arrangements for an ambulance to transport the student to the hospital with an extra auto injector (as provided by the student) to be administered approximately 10 to 15 minutes later, if needed.

4.15 Parents/guardians shall provide the school with information on how to reach them on short notice to advise or assist staff regarding emergency arrangements, including transportation to hospital. Current and accurate telephone numbers for parents/guardians and designated emergency contacts must be on file in the office. Note: In the event of an emergency, medication will be administered and an ambulance called even if parents cannot be reached.

4.16 A record of the use of the auto injector will be retained in the school office on Form OCDSB 287: Student Medication Log.

4.17 In administering the auto injector, the staff member is acting according to the principle "in loco parentis", not as a health professional, and is covered by the OCDSB's liability insurance.

4.18 If an OCDSB 616: Severe and Life-Threatening Allergy Protocol Registration has been completed and signed by a physician, and the parents/guardians are unable to provide

the school with two epinephrine auto injectors, the principal shall contact their Superintendent of Instruction to identify agencies that are able to provide support in acquiring auto injectors.

4.19 If the principal has determined that it is necessary to equip the school with one or more non-prescribed auto injectors, the parents/guardians of each child with a life-threatening allergy who were unable to provide the school with two Auto injectors, shall complete page 2 of OCDSB 405: Emergency Use of an Auto injector Authorization (Non-Prescribed).

4.20 If a plan for administration of prescribed medication cannot be agreed upon by the parent/guardian and the principal, the principal will contact the Superintendent of Instruction for resolution to ensure that a plan is put in place.

4.21 Parents/guardians must authorize the release of relevant information to those who may be involved in the care of the student by signing Form OCDSB 616: Severe and Life-Threatening Allergy Protocol Registration.

4.22 In a case where an OCDSB staff member has reasonable grounds to suspect that a student is having an anaphylactic reaction, and an OCDSB 616: Severe and Life-Threatening Allergy Protocol Registration has not been completed by the parent / guardian, the staff member will call 911 and seek direction prior to taking any action involving medication.

4.23 If so directed by a 911 operator, and if the school has a non-prescribed auto injector, a staff member may administer an epinephrine auto injector to the student that they suspect is having an anaphylactic reaction.

5.0 APPENDICES

(Samples only – Reference the OCDSB website or the Forms Conference on BEAM for the latest form)

Appendix 1 OSTA Life-Threatening Medical Conditions Emergency Transportation Form
Appendix 2 OCDSB 285: Self-Administration of Oral Medication Authorization
Appendix 3 OCDSB 286: Administration of Oral Medication Authorization
Appendix 4 OCDSB 287: Student Medication Log
Appendix 5 OCDSB 405: Emergency Use of the Auto injector Authorization
Appendix 6 OCDSB 616: Severe and Life-Threatening Allergy Protocol Registration
Appendix 7 OCDSB 802: Serious Medical Conditions Protocol Registration

6.0 REFERENCE DOCUMENTS

Ontario Ministry of Education and Training Memorandum No. 81, *Provision of Health Support Services in School Settings*,
Board Policy P.108.SCO Care of Students with Life-Threatening Medical Conditions
Board Procedure PR.548.SCO: Severe, Life-Threatening Allergies

OSTA
Ottawa Student Transportation Authority

LIFE-THREATENING MEDICAL CONDITION

Student Name:

Student #:

Address:

Phone #:

School: Grade:

STUDENT'S PHOTO HERE

LIFE-THREATENING MEDICAL CONDITION:

☐ **Life-Threatening Allergy/Anaphylaxis:**

Auto Injector can be found: _____

(Please indicate location of Epinephrine Auto Injector on pupil)

☐ **Epilepsy** ☐ **Asthma** ☐ **Heart Condition** ☐ **Pace Maker**

☐ **Diabetes** ☐ **Other** (specify)**:**_____

Consent for administration of medication form on file at school: ☐YES ☐NO

_____ _____

(Principal's Signature) **(Date)**

Use of this form is to be limited ONLY to pupils with life-threatening medical conditions that may require the emergency administration of an epinephrine auto injector, or other emergency medical attention, who ride a school bus or use small vehicle transportation.

This form shall contain a clear and recent photograph of the pupil.

Schools are to forward (3) copies of this form (one original form with original photograph and Principal signature, and no less than two photocopies of the completed form with clear photographs) to the Ottawa Student Transportation Authority. Forms are NOT to be given directly to the driver/transportation provider by parents/guardians or school staff.

TRANSPORTATION INFORMATION:

Pickup Bus: (ROUTE #) **Drop Off Bus:** (ROUTE #)

DISPATCH PROCEDURES:

1. Obtain exact location and time of administration.
2. Call 911.
3. Call Principal of School at 613- (phone number) or cellular at .
4. Maintain radio contact.

5. Call OSTA General Manager (or designate) at 613-224-8800 ext. 2580

Information contained on this form is confidential when complete.

Distribution: 1. OSTA 2. OSTA to provide to operator

OTTAWA-CARLETON DISTRICT SCHOOL BOARD

Self-Administration Of Oral Medication Authorization

(References: P.108.SCO and PR.547.SCO, PR.548.SCO and PR.632.SCO)

NOTE: Please type and submit the original, signed copy to your child's school principal in a timely manner. In the case of ongoing serious medical conditions (such as but not limited to severe, life-threatening allergies, diabetes, epilepsy, heart condition, asthma), this authorization will terminate on June 30 of each school year. Please ensure to notify the principal if the prescription changes or expires. This authorization may be cancelled upon receipt of written notification to the principal.

School Name: _____ Date: _____

Principal's Name: _____ Teacher's Name: _____

ADVISEMENT OF ADMINISTRATION OF ORAL MEDICATION

Student's Name: _____ Student No. : _____

Parent/Guardian (if student is under 18 years of age): _____

Telephone (Home): _____ Telephone (Business): _____

Address: _____

E-mail Address: _____

Physician's Name: _____ Physician's Telephone: _____

PHYSICIAN'S STATEMENT RE: ADMINISTERING ORAL MEDICATION DURING SCHOOL HOURS

In my opinion, it is necessary that the following medication be administered during school hours:

1. Name of Medication: _____
2. Storage Cautions, if any: _____
3. Dosage of Medication: _____
4. Time of Administration: _____
5. Special instructions for Administration: _____
6. Duration of Medication Regime: _____
7. Caution of Notable Side Effects: _____

Physician's Signature: _____ **Date:** _____

PARENT/GUARDIAN AUTHORIZATION RE: SELF-ADMINISTRATION

The responsibility for administration of medication involves certain elements of risk. Unexpected consequences including, but not limited to, illness, adverse reactions or other complications may occur as a result of the administration (or non-administration) of any medication. These physical reactions result from the medication and can occur without fault on the part of the student. By requesting and consenting to the self-administration of medication, you are assuming the risk of an unexpected reaction occurring. It is understood that the chances of such a reaction occurring may be reduced by carefully following the instructions provided by the physician and/or pharmacy at all times. If you consent to the self-administration of medication, you must understand that you will bear sole responsibility for any physical reaction that might occur.

I have read the above and I understand that in requesting and consenting to the self-administration of

medication, I am assuming the risks associated with doing so.

Name of Medication:_____Prescription No._____

The parent (s)/guardian (s) of: _____

hereby consent that the above medication shall be self-administrated by the student in accordance with the procedure outlined above by the physician.

Parent/Guardian Signature (or student if 18 years or older):_____

Date: _____

PARENT/GUARDIAN AUTHORIZATION RE: CONSENT TO RELEASE

I/we give consent for school staff to use and share the information provided in this form as required to attend to the education, health and safety of myself/my child. This may include:

The pertinent information contained within will be shared with the Ottawa Student Transportation Authority and applicable contracted bus operators (including your child's bus driver where appropriate);

Posting of the student's photograph (physical and/or electronic) in the school so that all staff, volunteers and visitors are aware of the medical condition;

And any such other circumstances that may be necessary to ensure the health and safety of your child.

Parent/Guardian Signature (or student if 18 years or older): _____

Date: _____

PARENT/GUARDIAN AUTHORIZATION RE:CONSENT TO TRANSFER TO HOSPITAL

I/we give consent for my child to be transported to a hospital if deemed necessary by school staff, and if necessary, a staff member may also accompany my child during transport. Note: The principal shall decide if an ambulance is to be called.

Parent/Guardian Signature (or student if 18 years or older): _____

Date: _____

The personal information on this form is collected under the authority of the Education Act and will only be used to record parental authorization for the self-administration by the student of the named medication. Access to this information will be limited to those who have an administrative need, to the student to whom the information relates and the parent(s)/guardian (s) of a student who is under 18 years of age. If you wish to review this information or have questions regarding its collection, please contact your school principal.

The information collected will be protected against theft, loss and unauthorized use or disclosure.

PRINCIPAL'S ACKNOWLEDGEMENT

I have reviewed the information provided in this form, obtained clarification if required, and acknowledge its receipt.

Principal's Signature: _____

Date: _____

THIS FORM MUST BE COMPLETED IN A TIMELY MANNER, INCLUDE ORIGINAL SIGNATURE(S) AND SUBMITTED TO THE SCHOOL PRINCIPAL.

OTTAWA-CARLETON
DISTRICT SCHOOL BOARD

Administration Of Oral Medication Authorization

(References: P.108.SCO and PR.547.SCO, PR.548.SCO and PR.632.SCO)

NOTE: Please type and submit the original, signed copy to your child's school principal in a timely manner. In the case of ongoing serious medical conditions (such as but not limited to severe, life-threatening allergies, diabetes, epilepsy, heart condition, asthma), this authorization will terminate on June 30 of each school year. Please ensure to notify the principal if the prescription changes or expires. This authorization may be cancelled upon receipt of written notification to the principal.

School Name:_____ Date:_____
Principal's Name: _____ Teacher's Name: _____

ADVISEMENT OF ADMINISTRATION OF ORAL MEDICATION

Student's Name: _____ Student No.: _____
Parent/Guardian (if student is under 18 years of age): _____
Telephone (Home): _____ Telephone (Business): _____
Address: _____
E-mail Address: _____
Physician's Name: _____ Physician's Telephone: _____

PHYSICIAN'S STATEMENT RE: ADMINISTERING ORAL MEDICATION DURING SCHOOL HOURS

In my opinion, it is necessary that the following medication be administered during school hours:

1. Name of Medication: _____
2. Storage Cautions, if any: _____
3. Dosage of Medication: _____
4. Time of Administration: _____
5. Special instructions for Administration: _____
6. Duration of Medication Regime: _____
7. Caution of Notable Side Effects: _____

Physician's Signature: _____ Date: _____

PARENT/GUARDIAN AUTHORIZATION RE: ADMINISTRATION

The responsibility for administration of medication involves certain elements of risk. Unexpected consequences including, but not limited to, illness, adverse reactions or other complications may occur as a result of the administration (or non-administration) of any medication. These physical reactions result from the medication and can occur without fault on either the part of the student or the Ottawa-Carleton District School Board (OCDSB) or its employees or agents. By requesting and consenting to the administration of medication by the OCDSB to your child, you are assuming the risk

of an unexpected reaction occurring. It is understood that the chances of such a reaction occurring

may be reduced by carefully following the instructions provided by the physician and / or pharmacy at all times. If you consent to the administration of medication to your child by the OCDSB, you must understand that you and not the OCDSB will bear sole responsibility for any physical reaction that might occur.

I have read the above and I understand that in requesting and consenting to the administration of medication by the OCDSB, I am assuming the risks associated with doing so.

Name of Medication: _____Prescription No.: _____

The parent (s)/guardian (s) of: _____

hereby consent that the above medication, using the procedures as outlined by the physician, be administrated to the student by the OCDSB, its employees or agents.

Parent/Guardian Signature (or student if 18 years or older): _____

Date: _____

It is acknowledged that the employees or agents of the OCDSB are not medically trained to administer medication.

Parent/Guardian Signature (or student if 18 years or older): _____

Date: _____

PARENT/GUARDIAN AUTHORIZATION RE: CONSENT TO RELEASE

I/we give consent for school staff to use and share the information provided in this form as required to attend to the education, health and safety of myself/my child. This may include:

The pertinent information contained within will be shared with the Ottawa Student Transportation Authority and applicable contracted bus operators (including your child's bus driver where appropriate);

Posting of the student's photograph (physical and/or electronic) in the school so that all staff, volunteers and visitors are aware of the medical condition;

And any such other circumstances that may be necessary to ensure the health and safety of your child.

Parent/Guardian Signature (or student if 18 years or older): _____

Date: _____

PARENT/GUARDIAN AUTHORIZATION RE:CONSENT TO TRANSFER TO HOSPITAL

I/we give consent for my child to be transported to a hospital if deemed necessary by school staff, and if necessary, a staff member may also accompany my child during transport. Note: The principal shall decide if an ambulance is to be called.

Parent/Guardian Signature (or student if 18 years or older): _____

Date: _____

The personal information on this form is collected under the authority of the Education Act and will only be used to record parental authorization for the self-administration by the student of the named medication. Access to this information will be limited to those who have an administrative need, to the

student to whom the information relates and the parent(s)/guardian (s) of a student who is under 18

years of age. If you wish to review this information or have questions regarding its collection, please contact your school principal.

The information collected will be protected against theft, loss and unauthorized use or disclosure.

PRINCIPAL'S ACKNOWLEDGEMENT

I have reviewed the information provided in this form, obtained clarification if required, and acknowledge its receipt.

Principal's Signature: _____

Date: _____

THIS FORM MUST BE COMPLETED IN A TIMELY MANNER, INCLUDE ORIGINAL SIGNATURE(S) AND SUBMITTED TO THE SCHOOL PRINCIPAL.

OCDSB 287 APPENDIX 4

OTTAWA-CARLETON
DISTRICT SCHOOL BOARD

Student Medication Log

(References: P.108.SCO and PR.547.SCO, PR.548.SCO and PR.632.SCO)

Student's Name: ______________________________ Student Number ______________________________

School Name: ______________________________ Grade/Room: ______________________________

Principal's Name: ______________________________ Home Form Teacher: ______________________________

Name of Medication: ______________________________ Dosage(s): ______________________________

Month: ____________________

Date	Time	Initial

Month: ____________________

Date	Time	Initial

Month: ____________________

Date	Time	Initial

Month: ____________________

Date	Time	Initial

Month: ______________________

Date	Time	Initial

Month:______________________

Date	Time	Initial

Month: ______________________

Date	Time	Initial

Month: ______________________

Date	Time	Initial

The personal information on this form is collected under the authority of the *Education Act* and will only be used to record the administration of medication to the named student. Access to this information will be limited to those who have an administrative need, to the student to whom the information relates, and to the parent(s)/guardian(s) of the student who is under 18 years of age.

OTTAWA-CARLETON DISTRICT SCHOOL BOARD

Emergency Use Of Auto-Injector Authorization (Epipen® or Allerject™) (Prescribed – Section 1)

(References: P.108.SCO and PR.547.SCO, PR.548.SCO and PR.632.SCO)

NOTE: Please type and submit the original, signed copy to your child's school principal in a timely manner. In the case of ongoing serious medical conditions (such as but not limited to severe, life-threatening allergies, diabetes, epilepsy, heart condition, asthma), this authorization will terminate on June 30 of each school year. Please ensure to notify the principal if the prescription changes or expires. This authorization may be cancelled upon receipt of written notification to the principal.

School Name: _____ Date: _____

Principal's Name: _____ Teacher's Name: _____

ADVISEMENT OF ADMINISTRATION OF ORAL MEDICATION

Student's Name: _____ Student No. : _____

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

Telephone (Home): _____ Telephone (Business): _____

Address: _____

E-mail Address: _____

Physician's Name: _____ Physician's Telephone: _____

PHYSICIAN'S STATEMENT RE: THE USE OF EPIPEN® OR ALLERJECT™AUTO-INJECTOR

In my opinion, it is necessary to use the Auto-Injector during school hours:

1. Name of Medication: _____
2. Storage Cautions, if any: _____
3. Dosage of Medication: _____
4. Time of Administration: _____
5. Special instructions for Administration: _____
6. Duration of Medication Regime: _____
7. Caution of Notable Side Effects: _____

Physician's Signature: _____ Date: _____

PARENT/GUARDIAN AUTHORIZATION RE: ADMINISTRATION

The responsibility for administration of medication involves certain elements of risk. Unexpected consequences including, but not limited to, illness, adverse reactions or other complications may occur as a result of the administration (or non-administration) of any medication. These physical reactions result from the medication and can occur without fault on either the part of the student or the Ottawa-Carleton District School Board (OCDSB) or its employees or agents. By requesting and consenting to the administration of medication by the OCDSB to your child, you are assuming the risk of an unexpected reaction occurring. It is understood that the chances of such a reaction occurring may be reduced by carefully following the instructions provided by the physician and / or pharmacy at all times. If you consent to the administration of medication to your child by the OCDSB, you must understand that you and not the OCDSB will bear sole responsibility for any physical reaction that might occur.

I have read the above and I understand that in requesting and consenting to the administration of medication by the OCDSB, I am assuming the risks associated with doing so.

Name of Medication: _____ Prescription No.: _____

The parent (s)/guardian (s) of: _____

hereby consent that the above medication, using the procedures as outlined by the physician, be administrated to the student by the OCDSB, its employees or agents.

It is acknowledged that the employees or agents of the OCDSB are not medically trained to administer medication.

Parent/Guardian Signature (or student if 18 years or older): _____

Date: _____

OTTAWA-CARLETON DISTRICT SCHOOL BOARD

EMERGENCY USE OF AUTO-INJECTOR AUTHORIZATION (Epipen® or Allerject™) (Non-Prescribed – Section 2)

(References: P.108.SCO and PR.547.SCO, PR.548.SCO and PR.632.SCO)

Note: This page must be completed by the parent / guardian if the principal has determined that it is necessary to equip the school with one or more non-prescribed Auto-Injectors, and the parents/guardians are unable to provide the school with two Auto-Injectors.

School Name: _____ Date: _____

Principal's Name: _____ Teacher's Name: _____

ADVISEMENT OF ADMINISTRATION OF ORAL MEDICATION

Student's Name: _____ Student No. : _____

Parent/Guardian (if student is under 18 years of age): _____

Telephone (Home): _____ Telephone (Business): _____

Address: _____

E-mail Address: _____

Physician's Name: _____ Physician's Telephone: _____

PARENT/GUARDIAN AUTHORIZATION RE: ADMINISTRATION OF A NON-PRESCRIBED AUTO-INJECTOR

I/we, _____ the parent(s)/guardian(s) of _____ hereby give my consent to the Ottawa-Carleton District School Board (OCDSB), in the event of an emergency and in the circumstances that a *prescribed* Auto-Injector (Epi-Pen® or Alerject™) is not readily available or not provided to the school, to administer a non-prescribed epinephrine auto injector on my child, which contains a dose of:

- ☐ 0.15mg of epinephrine
  or
- ☐ 0.30mg of epinephrine

The responsibility for administration of medication involves certain elements of risk. Unexpected consequences including, but not limited to, illness, adverse reactions or other complications may occur as a result of the administration (or non-administration) of any medication. These physical reactions result from the medication and can occur without fault on either the part of the student or the Ottawa-Carleton District School Board (OCDSB) or its employees or agents. By requesting and consenting to the administration of medication by the OCDSB to your child, you are assuming the risk of an unexpected reaction occurring. It is understood that the chances of such a reaction occurring may be reduced by carefully following the instructions provided by the physician and / or pharmacy at all times. If you consent to the administration of medication to your child by the OCDSB, you must understand that you and not the OCDSB will bear sole responsibility for any physical reaction that might occur.

I have read the above and I understand that in requesting and consenting to the administration of medication by the OCDSB, I am assuming the risks associated with doing so.

It is acknowledged that the employees or agents of the OCDSB are not medically trained to administer medication.

Parent/Guardian Signature (or student if 18 years or older): _____

Date: _____

OTTAWA-CARLETON DISTRICT SCHOOL BOARD

EMERGENCY USE OF AUTO-INJECTOR AUTHORIZATION (Epipen® or Allerject™) (General Authorizations- Section 3)

(References: P.108.SCO and PR.547.SCO, PR.548.SCO and PR.632.SCO)

PARENT/GUARDIAN AUTHORIZATION RE: CONSENT TO RELEASE

I/we give consent for school staff to use and share the information provided in this form as required to attend to the education, health and safety of myself/my child. This may include:

- The pertinent information contained within will be shared with the Ottawa Student Transportation Authority and applicable contracted bus operators (including your child's bus driver where appropriate);
- Posting of the student's photograph (physical and/or electronic) in the school so that all staff, volunteers and visitors are aware of the medical condition;
- And any such other circumstances that may be necessary to ensure the health and safety of your child.

Parent/Guardian Signature (or student if 18 years or older): _____

Date: _____

PARENT/GUARDIAN AUTHORIZATION RE: CONSENT TO TRANSFER TO HOSPITAL

I/we give consent for my child to be transported to a hospital if deemed necessary by school staff, and if necessary, a staff member may also accompany my child during transport. Note: The principal shall decide if an ambulance is to be called.

Parent/Guardian Signature (or student if 18 years or older): _____

Date: _____

The personal information on this form is collected under the authority of the Education Act and will only be used to record parental authorization for the self-administration by the student of the named medication. Access to this information will be limited to those who have an administrative need, to the student to whom the information relates and the parent(s)/guardian (s) of a student who is under 18 years of age. If you wish to review this information or have questions regarding its collection, please contact your school principal.

The information collected will be protected against theft, loss and unauthorized use or disclosure.

PRINCIPAL'S ACKNOWLEDGEMENT

I have reviewed the information provided in this form, obtained clarification if required, and acknowledge its receipt.

Principal's Signature: _____

Date: _____

THIS FORM MUST BE COMPLETED IN A TIMELY MANNER, INCLUDE ORIGINAL SIGNATURE(S) AND SUBMITTED TO THE SCHOOL PRINCIPAL.

OCDSB 616

APPENDIX 6

OTTAWA-CARLETON DISTRICT SCHOOL BOARD

Severe, Life Threatening Allergy Protocol Registration

(References: P.108.SCO and PR.547.SCO, PR.548.SCO and PR.632.SCO)

NOTE: Please type and submit the original, signed copy to your child's school principal in a timely manner. In the case of ongoing serious medical conditions (such as but not limited to severe, life-threatening allergies, diabetes, epilepsy, heart condition, asthma), this authorization will terminate on June 30 of each school year. Please ensure to notify the principal if the prescription changes or expires. This authorization may be cancelled upon receipt of written notification to the principal.

School Name: _____ Date: _____

Principal's Name: _____ Home Form Teacher's Name: _____

Student's Name: _____ Student No.: _____

Year/Grade: _____

Location of Auto-Injector (EpiPen® or Allerject™) on Student: _____

Pick-up/Drop-off Bus Route Numbers: _____

Transportation Address: _____

STUDENT'S PHOTO: PLEASE ATTACH A RECENT PHOTO OF STUDENT TO FORM

ALLERGIES: _____

Anaphylactic reaction (life-threatening) to (specify): _____

SYMPTOMS

An anaphylactic reaction can begin within seconds or exposure or after several hours. Any combination of the following symptoms may signal the onset of a reaction. Please indicate symptoms to watch for:

- ☐ Hives
- ☐ Itching (on any part of the body)
- ☐ Swelling (of any body parts, especially eyes, lips, face, tongue)
- ☐ Red watery eyes
- ☐ Runny nose
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Stomach cramps
- ☐ Change of voice
- ☐ Coughing (could sound like throat clearing)
- ☐ Wheezing
- ☐ Throat tightness or closing
- ☐ Difficulty swallowing
- ☐ Difficulty breathing
- ☐ Sense of doom
- ☐ Dizziness
- ☐ Fainting or loss of consciousness
- ☐ Change of colour

☐ Other _____

WARNING:

- Symptoms do not always occur in the same order or intensity, even in the same individuals.
- Time from onset of first symptoms to death can be as little as a few minutes if the reaction is not treated.
- Even when symptoms have subsided after initial treatment, they can return as much as eight hours after exposure.

GENERAL COURSE OF ACTION

Administer Medication and Call Ambulance Even if Parents/Guardians Cannot be Reached

If there is ANY suspicion that the student may have been exposed to his/her life-threatening allergies or is displaying any of the above symptoms:

- Use Auto-Injector IMMEDIATELY – Storage Locations: _____
  - (It is highly recommended that each student carry an EpiPen® or Allerject™ at all times, with back-up kept in the office or accessible location.)
- The student should rest quietly.
- Send a runner to immediately notify the principal or designate to call Emergency 911 and have Auto-Injector (if NOT carried by the student) delivered to the room immediately by an adult.
- Do not send the child to the office. (Time is of the essence and supervision essential.)
- The student must be transported immediately to the hospital with extra Auto-Injectors to be administered approximately 10/15 minutes later if needed.
- Monitor the student until the ambulance arrives.
- Have the student ready to go.
- Call parents/guardians:

Parent/Guardian Name:_____

Parent/Guardian Contact Number(s):_____

OR

Parent/Guardian Name:_____

Parent/Guardian Contact Number(s):_____

OR

Emergency Contact Name:_____

Emergency Contact Number(s):_____

SPECIFIC COURSE OF ACTION: (To be completed by Allergist/Physician)

Tastes or ingests allergic substance:_____

Skin contact with allergen: _____

Smells an allergen substance: _____

Other: _____

Instructions re Ambulance: _____

Allergist/Physician's Name: _____Telephone: _____

Allergist/Physician's Signature: _____ Date: _____

PARENT(S) / GUARDIAN(S) RESPONSIBILITY:

It is the responsibility of the parent(s)/guardian(s):

- To inform the principal of a pupil's medical needs if medication will be required during school hours;
- To inform the program supervisors of other OCDSB programs such as Lighthouse, or OCDSB facilitated programs such as Day Care, of a pupil's medical needs if medication will be required during their program hours;
- To request assistance of the school and discuss procedures that may be required;
- To ensure that accurate and up-to-date telephone contacts are available to the school;
- To submit all required documentation, such as a completed OCDSB 405: Emergency Use of an auto-injector and OCDSB 616: Severe, Life-Threatening Allergy Protocol Registration to the principal of the school.

Note: No medication may be left at school without authorization.

PARENT/GUARDIAN AUTHORIZATION RE: CONSENT TO RELEASE

I/we give consent for school staff to use and share the information provided in this form as required to attend to the education, health and safety of myself/my child. This may include:

- The pertinent information contained within will be shared with the Ottawa Student Transportation Authority and applicable contracted bus operators (including your child's bus driver where appropriate);
- Posting of the student's photograph (physical and/or electronic) in the school so that all staff, volunteers and visitors are aware of the medical condition;
- And any such other circumstances that may be necessary to ensure the health and safety of your child.

Parent/Guardian Signature (or student if 18 years or older): _____

Date: _____

PARENT/GUARDIAN AUTHORIZATION RE: CONSENT TO TRANSFER TO HOSPITAL

I/we give consent for my child to be transported to a hospital if deemed necessary by school staff, and if necessary, a staff member may also accompany my child during transport. Note: The principal shall decide if an ambulance is to be called.

Parent/Guardian Signature (or student if 18 years or older): _____

Date: _____

The personal information on this form is collected under the authority of the Education Act and will only be used to record parental authorization for the self-administration by the student of the named medication. Access to this information will be limited to those who have an administrative need, to the student to whom the information relates and the parent(s)/guardian (s) of a student who is under 18 years of age. If you wish to review this information or have questions regarding its collection, please contact your school principal.

The information collected will be protected against theft, loss and unauthorized use or disclosure.

THIS FORM MUST BE COMPLETED IN A TIMELY MANNER, INCLUDE ORIGINAL

SIGNATURE(S) AND SUBMITTED TO THE SCHOOL PRINCIPAL.

PRINCIPAL'S ACKNOWLEDGEMENT

I have reviewed the information provided in this form, obtained clarification if required, and acknowledge its receipt.

Principal's Signature: _____

Date: _____

A copy of this form must be kept with the Auto-Injector and in the student's classrooms, the lunchroom, and in other central locations where information regarding anaphylactic students is available.

Share this completed form with all of the student's teachers.

Use the review of this form as an opportunity to discuss the implementation of the guidelines with the parent(s)/guardian(s). Place a copy in the student's OSR folder.

OTTAWA-CARLETON DISTRICT SCHOOL BOARD

Serious Medical Conditions Protocol Registration

(References: P.108.SCO and PR.547.SCO, PR.548.SCO and PR.632.SCO)

NOTE: Please type or print neatly and submit the original, signed copy to your child's school principal in a timely manner. This authorization will terminate either on June 30 of each school year or upon notice of when the prescription changes or expires.

School Name: _____ Date: _____
Principal's Name: _____ Teacher's Name: _____
Student's Name: _____ Student No. : _____
Year/Grade _____
Pick-up and Drop-off Bus Route Numbers (if applicable): _____
Transportation Address: _____

STUDENT PHOTO: PLEASE ATTACH A RECENT PHOTO OF STUDENT TO FORM

MEDICAL CONDITION

☐ Epilepsy ☐ Heart Condition ☐ Pace Maker ☐ Asthma
☐ Other (specify):

SYMPTOMS AND WARNING SIGNS (To be completed by parent/guardian):

_____
_____
_____

COURSE OF ACTION (To be completed by parent/guardian):

_____
_____
_____

MEDICATION TO BE ADMINISTERED (if required):

(Administration of Oral Medication Authorization OCDSB 286 and/or Self-Administration of Oral Medication Authorization OCDSB 285 must be completed, signed and on file with the school principal.)

_____
_____
_____

CALL PARENTS/ GUARDIANS:

Parent/Guardian: _____

Telephone (Home): _____
Alternate Telephone Number: _____
OR
Parent/Guardian: _____
Telephone (Home): _____
Alternate Telephone Number: _____

Principal shall decide if an ambulance is to be called.

Parent/Guardian Signature (or student if 18 years or older): _____

Date: _____

The personal information on this form is collected under the authority of the Education Act and will only be used to record parental authorization for the administration of the named medication to the student by Board staff. Access to this information will be limited to those who have an administrative need, to the student to whom the information relates, and the parent(s)/guardian(s) of a student who is under 18 years of age. If you wish to review this information, please contact the school Principal.