SUDBURY CATHOLIC
DISTRICT SCHOOL BOARD

Medical Conditions

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APG# SS41: Medical Conditions

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PREAMBLE

This Medical Conditions Protocol addresses the components of Ministry of Education Policy/Program Memorandum 161 Supporting Children and Students with Prevalent Medical Conditions (Anaphylaxis, Asthmas, Diabetes, and/or Epilepsy) in Schools. This protocol also addresses concussions, administering medication and transportation for students with health concerns.

Rationale for a Medical Condition Protocol
The goal of these protocols is to educate school personnel about the medical conditions, their causes, symptoms and treatments so that a child diagnosed with the medical condition can have the support needed in the school setting or on a school trip to be safe and successfully participate in their education.

Purpose
The purpose of this APG is to promote the safety and well-being of all students. The SCDSB expects all schools within the Board support students in schools who have medical conditions. These medical conditions, hereafter referred to as prevalent medical conditions, have the potential to result in a medical incident or life-threatening emergency.

Supporting students with prevalent medical conditions in schools is complex. A whole-school approach is needed where education and community partners, including health care professionals have important roles to play in promoting student health and safety and in fostering and maintaining healthy and safe environments in which students can learn.

In developing, revising, implementing, and maintaining their policies to support students with prevalent medical conditions, schools should take into account local needs and circumstances, such as geographical considerations, demographics, and cultural considerations, as well as the availability of supports and resources, including school staff, within the school board and community. School boards should consult with parents, students, principals' associations, teachers' federations, education workers' unions, school staff, volunteers working in their schools, their school councils, Joint Health and Safety Committees, community health care professionals, Parent Involvement Committees, and Special Education Advisory Committees.

GUIDELINES

Specific protocols for the following prevalent medical conditions can be accessed in the appendices.
Anaphylaxis- Appendix A
Asthmas – Appendix B
Diabetes – Appendix C
Epilepsy – Appendix D
Concussions – Appendix E

Other medical conditions follow our standard protocol SE29A (full information) SE29B to be posted in visible location

Administration of Student Medication (excludes Epi-pen and Puffer)

1. Administration of medication shall be in accordance with the following procedures:
   1.1. All medication is to be given to the principal or designate (e.g. the school secretary, educational assistant, teacher-in-charge, classroom teacher) for control and administration
   1.2. The request for this service, the "Administration of Medication to Students", and the authorization to provide such service must be made in writing by the parent/guardian on the appropriate Student Medication Form.
   1.3. Under special circumstances (e.g. Field Trips) the principal may designate staff member(s) to be responsible for the administration of medication and record keeping.
   1.4. On the appropriate form (available at the school office) the parent/guardian shall request and authorize the administration of medication.
      1.4.1. Authorization for the medication is valid only for the school where the student is registered. If the child transfers within the board, the authorization needs to be confirmed upon the student's arrival at the new school.
      1.4.2. Authorization for any change in the medication dosage shall require the completion of a new request and consent for the Student Medication form.
      1.4.3. The authorization must be completed and renewed at the beginning of each school year.
      1.4.4. Administration of medication shall be in compliance with the directions given by the physician and/or prescription line from the pharmacy.
   1.5. A separate authorization form is required for each medication.
   1.6. Staff shall only administer medication that has been received in a clearly marked, original container with the prescription label from the pharmacy.
      1.6.1. It is best practice to have the pharmacy dispense both a home and school prescription in the event medication needs to be shared between home and school.
      1.6.2. Where possible, schools should only accept the exact dosage required for student use during school hours.
   1.7. In the event that the dosage of medication is missed or, at the time that it was given has passed, the parent/guardian shall be notified as soon as possible to seek further direction.
   1.8. The staff will write in the medication log that the medication was missed or the time to be given was passed, the time of the telephone call and the direction given by the parent/guardian will be recorded.
   1.9. Staff may give medication if missed at home in the morning, with verbal consent from the parent/guardian, only if indicated on the original student medication form; the designate will record the administration of medication given in the morning and the verbal consent given by the parent/guardian.
   1.10. Consideration shall be given for the removal of the student health care binder during a school emergency evacuation.
   1.11. The parent/guardian may request the Principal to administer over-the-counter medication, such as Tylenol. The same procedure as indicated for prescribed medication is to be followed for over-the-counter medication.
   1.12. Under no circumstances, should a principal, teacher or designate administer over-the-counter medication to a student, if the student is feeling ill (e.g. Tylenol, cough drop)

2. SECURITY, STORAGE, HANDLING
   2.1. Individual circumstances in each school will dictate where the medication is best stored.
   2.2. Medication is to be maintained in the secured location with the Health Care Binder; medication located in the classroom should also have a copy of the student's consent forms and Record of Administration of Medication Tracking Form. The principal is to keep the original copy of the Request and Authorization for the Administration of Medication forms at the office in the Student Health Care Binder.
   2.3. The parent/guardian will be contacted if the principal has concerns about the student's ability to safely store and self-administer medication an alternative plan will then be discussed and put in place for the administration of medication.

2.4. The parent/guardian shall be notified of any unused and expired medication. Parent/guardian shall be responsible for the removal of any unused medication at the end of the school year and be responsible to remove and replace expired medication.
2.5. Parents/guardians who do not pick up medication will be informed that the medication will be properly discarded by the principal. The principal/designate will disposed of any expired or unused medication with the local pharmacist.

3. RECORD KEEPING
3.1. The completed Student Medication form shall be filed alphabetically in the Student Health Care Binder and kept near the medication for easy access or where the medication is being dispensed. The medication and the Record of Administration of Medication Tracking form may be kept in the teacher's classroom, if the medication is stored and administered in the classroom.
3.2. For students on multiple medications, a separate Record of Administration of Medication form is needed for the dispensing of each medication.
3.3. A record of the supervision and/or administration of the medication shall be maintained by the staff member(s) responsible for the administration of the medication.
3.4. The principal is responsible to ensure that, if that information is not presently in the student database or in the Student Health Care Binder. This file should contain current treatment and other information, including a copy of any prescriptions, and instructions from the pupil's physician or nurse and a current emergency contact list.
3.5. The parent/guardian shall be given a copy of the administration record at the completion of the regimen, only if requested by parent/guardian.
3.6. The Principal shall keep on file the administration record for the remainder of the year, or longer if he/she deems advisable.

4. STUDENT MEDICATION FORM
4.1. The Student Medication Form will be developed, where necessary, in consultation with the parents/guardians, and when necessary, the appropriate health professionals. It will address as required the responsibilities, procedures, transportation of students, storage and administration of medication.
4.2. The Principal will ensure that all appropriate staff (e.g. lunch hour supervisors, long-term occasional teachers, etc.) are in-serviced by appropriate personnel regarding the Student Medication Form.
4.3. Each Student Medication Form shall be reviewed and updated as required.
4.4. The Student Medication Form shall be placed in the Student Health Care Binder with the accompanied Administration Medication Log. In the case that the medication is administrated in the classroom then the original copies shall be filed in the health care binder when the medication is completed or the school term ends.
4.5. The parent/guardian will meet with the principal after health concerns have changed (e.g. after an operation, development of new health concerns, etc.)

Transportation of Student with Health Concerns

1. Transportation service may be provided for students with a permanent physically disability or special education students identified by the school board as requiring special transportation. Where an IPRC decision to provide transportation services to such students has been made, the students will be picked up at their residence each morning and dropped off at their residence at the end of the school day. The Superintendent of Transportation or designate must approve the transportation of special education students.
2. Subject to the discretion of the Superintendent in charge of transportation, transportation services may be provided for students for health reasons. In applying for such transportation services, the family will provide the Consortium the Medical Information Form a qualified medical practitioner. It will indicate the nature of the student's medical condition, the reason for which

transportation is required and the estimated length of time for which transportation is needed. The service may be provided to the student with the medical condition only. No siblings will be approved for transportation on the vehicle used to transport the student with the medical condition.

3. It is the responsibility of the parent/guardian to advise the Consortium of the Health Concerns of their child.
4. It is the responsibility of the parent/guardian to request that the Sudbury Student Services Consortium agents administer medication while the student is on the bus.
5. The parent/guardian needs to complete the necessary form: the “Request for the Administration of an EpiPen” so that the Consortium personnel may administer the EpiPen.
6. If the school should receive a telephone call from the Consortium and is unable to reach parents/guardians, the school will attempt to reach the parents/guardians regarding the telephone call and the incident on the school bus.
7. The Principal/designate will ensure that Student Information is kept accurate and up-to-date in the Student Information System.

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SE29a
OSR FILE
Jan 2019
Colour - white

Student's Individual Medical Plan

A. IDENTIFICATION

Click in the box below to insert image

Date:	OEN:	
Student's Name:	DOB: Grade:	
School:	Teacher:	
Exceptionality: ☐ Yes ☐ No _____ Verbal Skills: ☐ Yes ☐ No ☐ Sign	First Language: ☐ English ☐ French ☐ Other	

B. PARENT/GUARDIAN INFORMATION

Mother/Guardian Name:		Home: Cell:	Business: Other:
Father/Guardian Name:		Home: Cell:	Business: Other:
Emergency Contact:		Phone:	

C. PHYSICIAN'S INFORMATION

Family Doctor:	Phone:
Alternative:	Phone:

D. MEDICATION INFORMATION

Medical Condition:	
*****SEND MEDICATION IN **ORIGINAL** CONTAINER*****	
Name(s) of drug:	
☐ Oral ☐ Drops ☐ Ointment ☐ Suppository ☐ Inhaler ☐ Injection ☐ EpiPen	
Reason:	
Dose to be Given:	**Times to be Given:**

Note: In accordance with the **Municipal Freedom of Information and Protection of Privacy Act,** the information provided on this form will be used solely for recording purposes and for use in the Ontario School Record. This report is confidential and any disclosure, copying or distribution is subject to the **Personal Health Information Protection Act** (PHIPA), 2004.

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Student's Individual Medical Plan

For Inhaler Medication: Chamber: ☐ Yes ☐ No	**Sequence/Time between puffers:** **# of Puffers at school:**

NOTE: If student has Asthma – Please complete the **INDIVIDUAL STUDENT ASTHMA MANAGEMENT PLAN**

For Injection Medication:

Route to be Given: ☐ Intramuscular ☐ Subcutaneous

For EpiPens/Allerject Medication: Complete the **ANAPHYLAXIS EMERGENCY PLAN** and note Avoidance Strategies and Symptoms of an Allergic Reaction below.

Allergies: Anaphylactic Reaction (Life Threatening): ☐ **Yes** ☐ **No**

AVOIDANCE Strategies:

-
-
-
-
-

SYMPTOMS of an Allergic Reaction:

-
-
-
-
-

Length of Treatment:

Medication Expiry Date:

Unused Medication will be Returned: ☐ Yes ☐ No **If yes:** ☐ Christmas ☐ March Break ☐ Summer

Location and Storage:

Special Instructions:

Possible Side Effects:

Special Circumstances under which medication SHOULD NOT be administered:

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Student's Individual Medical Plan

E. EMERGENCY ACTION PLAN

☐ Give Medication: Directions to follow:
☐ Call 911 ☐ Special Circumstances to call 911:
☐ Call Parents/Guardians Phone #:
☐ Call Emergency Contact Phone #:
☐ Other Special Instructions:

F. PARENT/GUARDIAN AUTHORIZATION FOR INDIVIDUAL MEDICAL PLAN AND EMERGENCY PROCEDURES

Date:
Parent/Guardian Signature:
Parent/Guardian Signature:

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Colour - white

Student's Individual Medical Plan

EMERGENCY PROCEDURES

Click in the box below to insert image

Date:	OEN:	
Student's Name:	DOB:	
	Grade:	
School:	Teacher:	
Exceptionality: ☐ Yes ☐ No _____ Verbal Skills: ☐ Yes ☐ No ☐ Sign	First Language: ☐ English ☐ French ☐ Other	

MEDICAL CONDITION:

Please state the students medical condition(s) here

SYMPTOMS:

Please list specific symptoms the child may exhibit in a medical emergency

EMERGENCY PRODEDURES:

Location of emergency supplies, emergency contact information, etc.

*This plan will be reviewed on an annual basis (or earlier) at the request of either the school or parent. This page is not for use with Asthma and Anaphylaxis Students – See those forms for Emergency Plan.

SIGNATURES:

Principal:	**Parents/Guardians:**	**Teacher:**

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Revised:
April 2019

Administration of Medication to Students

Student: _____ Date of Birth: _____

School: _____ Grade: _____ Date: _____

Medication (by name): _____

Dosage: _____

Frequency and Time: _____

Method of administration: _____

_____

Date medication is to be given: _____ To: _____

Storage requirements: _____

_____

Possible side effects: _____

_____

Emergency medical treatment: _____

_____

Emergency medical treatment telephone number: _____

Physician's name: _____ Telephone number: _____

Parent's name: _____ Telephone number: _____

_____ _____

Physician's Signature **Date**

_____ _____

Parent's Signature **Date**

NOTE:

** The staff member must agree to be of assistance and have been given appropriate instruction/training by a qualified person, which may include the parent.

** Medication should be returned to the parent or guardian upon their request or when the school is closed for Christmas vacation, winter break, summer vacation and other periods of school closure.

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Revised:
April 2019

Administration of Medication to Students

STUDENT'S NAME: _____

DATE OF BIRTH: _____ **GRADE:** _____

DATE	TIME	DOSAGE GIVEN	AMOUNT REMAINING	SIGNATURE OF STAFF MEMBER

Appendix A: Anaphylaxis Protocol

Introduction

This Anaphylaxis Protocol addresses the components of Ministry of Education Policy/Program Memorandum 161 Supporting Children and Students with Prevalent Medical Conditions (Anaphylaxis, Asthmas, Diabetes, and/or Epilepsy) in Schools.

Rationale For an Anaphylaxis Protocol

An Act to Protect Anaphylactic Pupils enacted by the Ontario Legislature came into force January 1, 2006. The act states that every School Board shall establish and maintain an anaphylaxis policy. The Anaphylaxis Protcol is to assist in developing a safe and inclusive environment by providing information to school personal about anaphylaxis (what it is, it's causes, symptoms, and treatment), and their responsibilities to assist the child diagnosed with anaphylaxis to manage their life threatening allergy.

What is Anaphylaxis?

(From: Supporting Ontario Children and Students with Medical Conditions)
Anaphylaxis (pronounced anna-fill-axis) is a serious and possibly life-threatening allergic reaction that requires immediate recognition and intervention. Symptoms can vary from person to person and may include:

- Skin: hives, swelling (face, lips and tongue), itching, warmth, redness
- Breathing (respiratory): coughing, wheezing, shortness of breath, chest pain/tightness, throat tightness, hoarse voice, nasal congestion or hay fever-like symptoms (runny, itchy nose and watery eyes, sneezing), trouble swallowing
- Stomach (gastrointestinal): nausea, pain/cramps, vomiting, diarrhea
- Heart (cardiovascular): paler than normal/blue skin colour, weak pulse, passing out, dizziness or light-headedness, shock
- Other: anxiety, sense of "doom" (the feeling that something bad is about to happen), headache, uterine cramps, metallic taste

Diagnosis of Anaphylaxis

A medical physician (family doctor, emergency physician) is often the first to identify an allergic patient. People thought to be at risk of life threatening allergic reactions should be evaluated by an allergist. Diagnosis includes a detailed personal history and confirmation of an allergy through appropriate investigations such as skin and/or blood tests. Patients diagnosed as being at risk of anaphylaxis are instructed that absolute avoidance of the allergy-causing subsance is necessary to avoid future reactions. They must carry an epinephrine auto-injector (e.g. EpiPen®) at times and should wear medical identification such as a Medic-Alert bracelet or necklace.

Triggers - Life-Threatening Allergens

Although many substances have the potential to cause anaphylaxis, the most commons triggers are foods and insect stings. In Canada, allergy causing foods are most often:

- Peanuts, tree nuts (e.g. almond, hazelnut, cashew, pistachio etc.)
- Milk
- Egg
- Fish, shellfish
- Sesame seeds, soy, wheat and mustard

- Medications and latex rubber can also potentially cause life-threatening allergic reaction
- Insect stings (wasps, bees)
- Strenous excercise can trigger anaphylaxis in some sensitized individuals after they eat a certain food that is not normally problematic. In these individuals, anaphylaxis only occurs if ingestion of the food allergen is followed by exercise or vigorous physical activity within hours of ingestion. Neither the food allergen nor exercise alone can trigger the anaphylactic reaction. In other individuals, anaphylaxis may be triggered by exercise alone. In some cases of anaphylaxis, the cause is unknown ('idiopathic')

Factors that May Increase the Risk of a Severe Anaphylatic Reaction

Anaphylaxis and Asthma

People with Asthma who also diagnosed with anaphylaxis are more susceptible to severe breathing problems when experiencing their anaphylactic reaction. It is extremely important for asthmatic patients to keep their asthma well-controlled. In cases where an anaphylactic reaction is suspected, but there is uncertainty whether or not the person is experiencing an asthma attack, epinephrine should be used first. Epinephrine can be used to treat life-threatening asthma attacks as well as anaphylactic reactions. Asthmatics who are at risk of anaphylaxis should carry their asthma medications (e.g. puffers/inhalers) with their epinephrine auto-injector (e.g. EpiPen®).

Under-utilization and delay in the use of epinephrine

Epinephrine is the drug of choice to treat an anaphylactic reaction and needs to be given early in the course of a reaction. It is imperative that all patients, parents of children at risk, teachers, and caregivers know the signs and symptoms of anaphylaxis and the correct use of emergency medication (e.g. epinephrine auto-injector).

Signs and Symptoms

Signs and symptoms of a severe allergic reaction can occur within minutes of exposure to an allergen. An anaphylactic reaction can involve any of the following symptoms, which may appear alone or in any combination, regardless of the triggering allergen:

Skin system: hives, swelling, itching, warmth, redness, rash
Respiratory system (breathing): coughing, wheezing, shortness of breath, throat tightness, hoarse voice, nasal congestion or hay fever like symptoms (runny nose and watery eyes, sneezing), trouble swallowing
Gastrointestinal system (stomach): nausea, pain/cramps, vomiting, diarrhea
Cardiovascular system (heart): pale/blue color, weak pulse, passing out, dizzy/lightheaded, shock
Other: anxiety, feeling of 'impending doom', headache, metallic taste

Note: it is important to note that anaphylaxis can occur without hives.

NOTE: Symptoms may vary with each individual, depending on the specific food and quantity ingested, and may be only one or any combination of the symptoms above. Time from onset of first symptoms to death can be in as little as a few minutes, if the reaction is not treated immediately. Even when symptoms have subsided after initial treatment, they can return within 8 to 12 hours after the first exposure.

Medication – Epinephrine

Epinephrine - also known as adrenaline - is the drug form of a hormone that the body produces naturally. Epinephrine is the treatment or drug of choice to treat anaphylaxis and as a result is prescribed by a physician for those at risk of anaphylaxis. Treatment protocol is through the use of epinephrine auto-

injector. Epinephrine helps to reverse symptoms of an allergic reaction by opening the airways, improving blood pressure, and accelerating heart rate.

There are no contraindications to use an epinephrine for a life-threatening allergic reaction. Simply put, this means that in normal healthy individuals, epinephrine will not cause harm if given unnecessarily. Possible side effects from epinephrine can include: rapid heart rate, flashing or pallor (paleness), dizziness, weakness, tremors and headache. The side effects are generally mild and subside within a few minutes.

Key Points

Epinephrine is the first line medication which should be used in the emergency management of a person having a potentially life-threatening allergic reaction.

- Antihistamines and asthma medication must not be used as first-line treatment for an anaphylactic reaction.
- In studies of individuals who have died as a result of anaphylaxis, epinephrine was under used, not used at all, or administration was delayed.
- Recommended that epinephrine be given at start of any suspected anaphylactic reaction occurring in conjunction with a known or suspected allergen contact.
- Epinephrine is to be injected into the muscle on the outer side of the thigh.

Additional epinephrine (second epinephrine auto-injector) must be available. The second dose may have to be administered within 10-15 minutes, or sooner, after the first dose is given IF symptoms have not improved.

Duty of Care

An Act to Protect Anaphylactic Pupils, 2005 (Sabrina's Law)

https://www.ontario.ca/laws/statute/05s07
Requires that every school board establish and maintain an anaphylactic policy, which must include, among other things, strategies to reduce risk of exposure to anaphylactic causative agent; a communication plan for the dissemination of information on life-threatening allergies; also a requirement that every school principal develop an individual Plan of Care for each pupil who has an anaphylactic allergen; and a requirement that every school principal maintains a file for each anaphylactic pupil.

Education Act

Education Act 265 (1): Duties of Principals

j) care of pupils and property – to give assiduous attention to the health and comfort of the pupils

Education Act, Regulations: Reg. 298, S20: Duties of Teachers

g) ensure that all reasonable safety procedures are carried out in course and activities for which the teacher is responsible

Common Law Duties Owed by Teachers

To assist or allow a student to seek medical attention as a careful parent would. The board's liability policy provides coverage for employees acting within the scope of their duties with the board. Best, all school staff who administer first aid to a student who is suffering from an anaphylactic emergency within the school or during a school activity, are covered.

Communication of Information on Anaphylaxis

The board public webpage offers resources that include information about anaphylaxis that can be shared with all parents/guardians, students, employees, volunteers, coaches and other persons who have direct contact with a student with anaphylaxis. School administrators are asked to consider these links in school newsletters, on the school website or in other pertinent areas, or in a letter home to all parents/guardians at the beginning of the school year.

This information is intended to assist people in understanding how to reduce exposure to anaphylaxis triggers, and how to manage anaphylaxis symptoms exacerbations.

The school principal/designate shall work with staff and families to help ensure that an anaphylaxis friendly school environment exists that is safe and supportive for all students.

Identification

Have a process in place where children with an anaphylactic condition are identified to the school system by parents/guardians and are requested to supply information on the anaphylactic condition.

- **Students, new to the school, during registration**
  Question during intake meeting specifically asking whether or not child is anaphylactic (or has any other medical conditions). Anaphylaxis Student Plan of Care provided to parent/guardian for further information regarding anaphylaxis triggers, etc.
- **Students presently registered at school**
  At the beginning of each school year, the school principal/designate shall have a process in place of requesting parent/guardian/adult student to identify if there is a new diagnosis of anaphylaxis (throughout the school year)
- **Ensure students medical condition(s) are entered** into the board's student database system.
- **Principals will ensure the creation/revision** of the Student Plan of Care and keep a copy of any prescriptions
- **Principals will ensure regular training** on dealing with life-threatening allergies for all employees and others who are in direct contact with pupils on a regular basis. (Sabrina's Law 2.3.)

Development of Anaphylaxis Student Plan of Care

The parent/guardian in consultation with the principal shall create, review and update the plan of care during September, or on the date as requested by the school administrator.

The plan shall be reviewed by the principal/designate in consultation with the parent/guardian/adult student following the anaphylaxis protocol, on an annual basis or when there is a change in the child's condition or changes to the prescribed medication. Where appropriate the classroom teacher is to be part of the information sharing process.

The child's anaphylaxis triggers are to be identified and avoidance strategies are to be developed and implemented.

Location of Epinephrine Auto Injectors (EpiPen®)

The Sudbury Catholic District School Board's choice for the epinephrine auto-injectors is EpiPen®

- **Number of EpiPens®**
  - Students are to have access to two EpiPens®

- **Location of the EpiPen®**
    - One is to be in close location to the child - Grades 1 to 12, the student, where capable of doing so, is to carry their EpiPen® with them at all times. Kindergarten teachers are to have the child EpiPen® in the classroom (e.g. teacher's desk), outside the classroom (with the supervising teacher).
    - The second EpiPen® is to be located in a safe, secure (NOT locked), readily accessible location at all times. All school staff are to be informed of the location of the epinephrine auto-injector - EpiPen®.
    - Conditions for storage: protect from light; store at room temperature; protect from freezing; and do not refrigerate.

For compliance with the Sudbury Catholic DSB epinephrine auto-injector protocols, refer to the following letters to parents.

- Sample letter to parents/guardians for the child to carry their EpiPen®
- Sample letter to parents/guardians re: students to supply two EpiPens® - one to be kept in a secure location in the school

Look-alike products to Peanut Butter

(e.g. SchoolSafe Soy Butter – WOWBUTTER; Sunbutter (sunflower seeds); Golden Pea Butter (peas and Omega 3 canola oil, etc.)

School administrators are to communicate with the school community to refrain from sending look-alike products to peanut butter to school with children. Refer to sample: anaphylaxis letter re-: peanut/tree nuts to school community.

It is impossible to differentiate between these products and peanut butter; in fact, these products are almost identical in color, consistency, smell and taste of peanut butter. Therefore, the board is requesting that parents do not send their children to school with look-alike products to peanut butter in sandwiches until the products are available in a colour other than tan, the colour peanut butter.

If not already done so, please bring the above information to the attention of your school community via your school newsletter and/or school website.

If a student brings this product into the school, an alternative setting to eat their lunch/snack is to be provided.

Treatment For An Anaphylactic Reaction

A.C.T.

- **Administer** the auto injector
- **Call 911**
- **Transport** to hospital by ambulance
- **Administer the epinephrine auto-injector - EpiPen®:**
  - Be prepared to assist or take over the administration of the auto injector, as individuals may not physically be able to self-administer the epinephrine when they are suffering from a reaction. Assistance from others is crucial in these circumstances.
  - Administer the epinephrine auto-injector, immediately, at the first signs/symptoms of an anaphylactic reaction occurring in conjunction with a known or suspected allergen contact. Epinephrine is usually effective after one injection.
  - Access the student's other auto-injector and have it brought to the location of the anaphylactic person. A second dose may be administered, within 5 to 10 minutes or sooner, if symptoms have not improved or have worsened.
- **Call 911:**
  - Call person is to inform the emergency operator that a student/individual is having an anaphylactic reaction. (Note: use the terminology **anaphylactic reaction**). The call person should know the address of the school, the names of the closest cross streets and the entrance location.
  - Inform the principal and/or first aid provider.
- **Transfer care to the paramedics**:
  - Have an individual meet the ambulance at the appropriate entrance and take the ambulance personnel to the location of the student.
  - Provide the paramedics with a copy of the child's Plan of Care.
  - Notify the paramedics of the times that the medication was administered.
- **Transport to hospital by ambulance:**
  - All individuals receiving emergency epinephrine must be transported to hospital immediately for evaluation and observation for an appropriate period (e.g. 4 hours) because of the possibility of a bi-phasic or prolonged reaction.
  - One common familiar person must stay with the child until a parent/guardian arrives.

Contact parents, as soon as reasonably possible, informing them of their child's medical situation and the hospital their child was taken to.

How to Administer an EpiPen®

NOTE: The EpiPen® Trainer does NOT contain a needle

Administer the EpiPen® immediately, at the first sign of reaction, in conjunction with the child's contact with their life-threatening allergen.

Injection procedures: ("Blue to the sky - Orange to the thigh")

1. Remove the EpiPen® from its case
2. Hold the EpiPen® along the shaft keeping thumbs and fingers away from both ends of the auto injector
3. Pull off the end safety CAP (Blue cap).
4. Injection location is the MIDDLE OF THE OUTER THIGH. NO other location.
5. Hold student's leg steady to prevent it from moving during injection.
6. Place injecting end of the EpiPen® (orange tip) against the MID-OUTER THIGH and jab/press firmly enough to disengage the needle on the EpiPen® into the leg. (Listen for a 'click').
7. Keep the EpiPen® on the leg for 10 seconds, to allow medication to enter the leg. (Count one – one thousand, two – one thousand etc.) After the 10 second count remove the EpiPen® from the leg.
8. When the EpiPen® is removed from the leg check that the needle on the EpiPen® was disengaged. (In the newer EpiPens® the orange cap Is extended over the needle and the window on the side of the EpiPen® indicates successful use.) If the needle was not disengaged – try again – pressing more firmly.
9. Massage the injection area for a 10 second count.
10. If symptoms do not improve, or if symptoms re-occur, administer a second EpiPen® after approximately 5 to 10 minutes or sooner. "Signs that the reaction is not under control are that the person's breathing becomes more laboured or there is a decreased level of consciousness."
11. Location of second injector site is 2 to 3 cm away from the initial injection site on the same leg.

Student's body position after receiving epinephrine:

- Place person on their back with her legs raised above heart level.
- Do not have the student immediately set up, stand or walk around.
- Direct emergency responders to the student. Do not have Student walk to emergency responders.

If the student is having difficulty breathing:

- Position them in and upright sitting position.

If the student feels sick or vomiting:

- Place the person in recovery position-on their side with their head down so the airway is clear and they do not choke on vomit.

Also:

- If food or drink is suspect, rinse out the mouth.
- If inhaled reliever medication is available, give it.

Note: if you forget any of the steps read instructions along the side of the EpiPen®.

The needle of the EpiPen® can penetrate one layer of clothing.

There are no contraindications to using epinephrine.

In normal healthy individuals, epinephrine will not cause harm if given unnecessarily. Possible side effects from epinephrine can include: rapid heart rate, paleness, dizziness, weakness, tremors and headache. These side effects are generally mild and subside within a few minutes.

Accidental injection into caregiver/patient's fingers:

Care should be taken, before administering an injection, to ensure that the needle end of the auto-injector is administered. Accidental injection into the hands may result in loss of blood flow to the infected area.

If there is an accidental injection the person should go immediately to the nearest emergency department for treatment.

Note: School administrators should consider simulating an anaphylactic emergency, with all staff, similar to a fire drill, to review and check to see that all elements of the school's emergency protocol are in place and everyone knows their role.

Field Trips and Students with Anaphylaxis (Day Trips, Overnight Trips, Extensive Trips, Exchange Programs):

- **Process in place to identify students with the diagnose life-threatening allergen - anaphylaxis**.
- **Trip site and activities are to be checked for potential safety hazards.** Where possible a pre-activity inspection of the site and activities by the in-charge teacher to investigate safety conditions e.g. bees/wasps, latex, food products that students have life-threatening allergy to.
- **Communicate with the child's parents/guardians** during the initial planning stages of the trip informing them of the destination, mode of travel and activities students are to participate in. This will allow for parent/guardian input in the school developing a clear set of expectations and accommodations to meet their child's medical needs on the trip. Knowing the trip expectations and accommodations the parents will be able to provide an informed decision as to their child's participation. You may consider inviting parent on the trip as a supervisor.
- Parents are to be consulted on medication to be taken – EpiPen®:
    - Day Trips – two EpiPens® to be taken.
    - Overnight/extensive/exchange trips - number of EpiPens® to be taken. Consideration given to distance from activity site to closest hospital/EMS. Availability of EpiPens® in the country of destination.
    - Conditions for storage of EpiPens® on route and at destination.
    - In-charge teacher to check with tour operator/activity provider for the distance from the activity location to the Emergency Medical Services (ambulance) and/or hospital. It is important when planning trips that a hospital and/or EMS be within the timeframe of the number of EpiPens® accessible to the student (EpiPen ®will last 10 to 15 minutes if administered correctly).
    - If allergen is a food allergy, student brings their own parent approved food. Where not possible parent provides information/list of foods to avoid during trip.
- **Tour operator and/or activity provider**
    - In-charge teacher is to identify the students with anaphylaxis and their life-threatening allergen.
    - Request operator to provide you with their accommodations for students with anaphylaxis.
    - Compare tour operator's plans for accommodations with school board expectations for accommodations for one of its students.
    - Adjust operator's accommodation plans accordingly to the needs of the student. Follow the plan wherever there is a higher standard.
    - If trip provider does not have a pre-existing plan for the student's medical condition, develop one of your own based on school board expectations and parent input and provide the operator with a copy.
    - Based on list of accommodations for the student the tour operator must provide:

        - Safe accommodations during travel to destination
        - Safe facilities, safe programming, safe foods at the destination
        - Ready access to a doctor, clinic or hospital at destination site
- **An emergency action plan for seizure** on the trip must be prepared by the in-charge teacher and communicated to all staff and volunteers on the trip.
- **Student forms on the trip –** copy of the student's Plan of Care along with trip accommodations, where appropriate, are to be taken on the trip.
- **Grouping of student(s)**: student is to be assigned to a group with staff member who is knowledgeable about managing and responding to an anaphylactic emergency.
    - This supervisor must know how to administer the EpiPen®.
- **Buddy system:** In situations where the teacher/supervisor is providing 'in the area supervision' the teacher is to assign a buddy to the student. The 'buddy's' responsibility is to assist the student and to access the teacher supervisors in case of an emergency.
- **A suitable means of communication** (e.g. cell phone) to be taken on the trip and/or an easily accessible phone is available at the site. Ensure that you have the correct and proper change if using payphones.
- **Trip supervisors to meet students** ahead of time who have anaphylaxis and provide the following information:
    - The importance of carrying the EpiPen® on their person at all times.
    - Check surroundings and implement avoidance strategies of your life-threatening allergens.
    - Strategies on how to deal with and resist peer pressure to 'try' something.
    - NOT to eat without their EpiPen®
    - Eat only food items approved by parents/guardians
    - Not to trade or share foods, utensils or food containers with others
    - Place a barrier placemat between the food and the eating service
    - Wash hands before and after meals
    - Eat with friends who are informed of the food allergy and they're able to help if a reaction happens. These friends would know the location of the EpiPen® and how to access an adult in authority
    - Not to go off alone (e.g. washroom) if they are feeling unwell or distressed
    - Advise an adult and/or others around them quickly if they feel they are having an allergic reaction.
    - Comply and assist, where possible, the administration of the EpiPen® from an adult in authority
- **Trip supervisor is to meet with the other students in the class** and provide the following information:
    - Inform the students in the class of the individual's life-threatening allergy to the food product, the consequences of the child ingesting the food product, how the ingestion can occur through cross contamination and outline how they can be a PAL to the student in the class:

PAL – Protect a Life from Food Allergies

1. Food allergies are serious. Don't make jokes about them.
2. Help your friend avoid the food allergy (e.g. avoid food and snacks made from the student's food allergen).
3. Don't share food with friends who have food allergies.
4. Wash your hands after eating.
5. If a friend who has food allergies becomes ill, get help immediately.
6. An EpiPen® contains lifesaving medication and is not to be played with.

Specific Conditions for Extensive Trips and Exchange Programs

- **Background check of the county or area of the country and activities**
    - Tour/trip provider
    - If you are going to a place where another language is spoken, try to learn the names of your student's allergen in the country you are visiting. Have key terms and phrases translated into that language
    - Learn the emergency number for emergency medical services (911 is used for Canada and the United States)
    - Research is to be done by the parents/school organizers into the following resources that provide food allergy translation cards in the language of some countries. Select if/where applicable.
        - https://allergytranslation.com
        - https://www.selectwisely.com
    - Preparation for travelling with a food allergy is to be provided to student and parents/guardians: Refer to the following resource: www.anaphylaxis.ca/en/parents/travelling.html
- **If a student is to be billeted with a host family.**
  In order for the student with food allergy to be billeted with a family, the host family must comply with ALL of the following expectations:
    - **Information:**
        - Host family is willing to make themselves knowledgeable about life threatening allergy to student and anaphylaxis by accessing resources.
        - Information about the allergen – how the allergen is named and used.
        - Methods of cross contamination.
        - Prevention and management.
        - Identification of an anaphylactic reaction (signs and symptoms)
        - Emergency care – A.C. T.
    - **PREVENTION:**

  The key to minimizing an anaphylactic emergency is absolute avoidance of the allergen. People with allergy to _____ must not share food or eat unmarked/bulk foods or products with a 'may contain' warning. The host family must agree to:

  Meals, snacks and refreshments

  The student's meals, snacks and drinks must be prepared without any trace of the allergen e.g. peanuts/nut tree nuts. Refer to information naming the possible products to avoid.

  Before foods are brought into the house they must be checked by reading the food labels for products that contain or 'may contain' the food allergen (e.g. peanut/tree nuts).

  Take-out foods that are brought into the house must first be checked, at the source, that it does not contain the allergen (e.g. peanuts/tree nuts).

Foods consumed outside of the house (e.g. restaurants). Contents of food must first be checked by questioning a knowledgeable person at the restaurant (e.g. manager and/or chef). Inform the person of the food allergies e.g. “This person is severely allergic to all nuts, fish and shellfish. Can your chef accommodate this individual?”

- **Emergency Action:**
    - **Host family must be willing to be trained in administering the EpiPen®** and feel comfortable and provide assistance and/or administer the EpiPen® to the student when needed
        - Calling emergency medical services
        - Having student taken to the hospital by ambulance
    - Location/storage of the student’s epinephrine auto-injector - EpiPens® in the home:
        - Safe, secure (NOT locked) location readily accessible at all times
        - All members of the family informed of the location of the EpiPens®
        - EpiPens® are to be stored at room temperature, protected from light, not to be refrigerated

Cooperative Education Placements

The cooperative placement teacher, prior to placing a student diagnosed with anaphylaxis, is to inform the contact at the proposed placement location of the student’s anaphylactic condition, along with the avoidance accommodations needed to be in place for the life-threatening allergen. Placement of the student can only take place when the contact person/manager can assure the site location can safely accommodate the student with anaphylaxis.

School staff with life-threatening allergies

Process in place where school staff are surveyed for life threatening allergies/anaphylaxis. Information on causative agents, location and epinephrine and emergency contacts are to be provided.

It is staff’s responsibility to inform school administers of the life-threatening allergen and the avoidance accommodations needed to be in place.

Appendix A

IMPLEMENTATION OF YEARLY TRAINING WITH STAFF

Content of the In-Service should take into consideration the following:

- Identification of students/staff with life threatening allergies.
- Define the term anaphylaxis. (Emphasize to participants the hazards of cross contamination and that the school as a whole is a 'minimized allergen environment', not just the classroom(s) of students with life threatening allergies).
- Provide an overview of the signs and symptoms of an anaphylactic reaction.
- Outline the school's Emergency Treatment Plan - A.C.T.
- Train participants how to administer the EpiPen®/Allerject auto-injector. Provide opportunities for regular practice.
- Inform participants of the location of where the second (spare) epinephrine auto injectors are kept in the school (e.g. resource room, office etc.)
- Field trip planning for students with anaphylaxis.
- Describe the risk reduction avoidance strategies that meets the need(s) of the anaphylactic students in the school
- Simulate an anaphylactic emergency, similar to a fire drill, to review and check to see that all elements of the school's emergency protocol are in place and everyone knows their role.
- Ensure that a process is in place by which On Call and Occasional Teachers are informed of the presence of an anaphylactic child by the classroom teacher.
    - When calling in an absence the teacher is to indicate on the SMART FIND system that there is a child with a life-threatening allergy and the location of the Child's Anaphylaxis Plan of Care.
    - Write information in the day/lesson plans – make reference to students with life threatening allergies (e.g. name(s), your class or in a rotary class, location of the Student's Anaphylaxis Plan of Care and location of stored EpiPens®.

Resources that can be used:

- Video – How to use EpiPen®
- Allerject – go to link – www.allerject.ca OR
- Staff training certificate at www.allergyaware.ca

Principals/delegate should keep a log of staff and others who have completed anaphylaxis training. Any staff members absent are to have in-service later

Appendix B

AVOIDANCE STRATEGIES

- The school as a whole is a ‘minimized allergen environment’, not just the classroom(s) of students with life threatening allergies.
- Products containing or ‘may contain’ peanuts or tree nuts are not to be brought into the school.
- In the classroom at lunch and snack time remove the hazardous allergen away from the anaphylactic student – seating location of the anaphylactic child in relationship to the allergen.
- Student hand washing before and after meals.
- Clean-up of eating surfaces of those with allergens
- Removal of uneaten food items and wrappers from vicinity of allergic student.
- Food items NOT used as incentives or reward to students.
- Anaphylactic students not to participate in garbage removal or yard cleanups.
- Minimize or eliminate the number of celebrations in the classroom/school where food is used (e.g. birthday celebrations).
- Food providers (caterers, restaurants) are to be informed of students with life threatening food allergens and must guarantee that their food products do not contain or ‘may contain’ any of the identified food allergens.
- Place a barrier (placemat) between the food and the eating surface of student.
- Reminders sent to parents/guardians during holiday times and celebrations (e.g. Halloween, Christmas, and Easter) that the school is a ‘minimized allergen environment and food items with peanut/tree nuts are not to be brought on school site
- ***Look-alike products to peanut butter are not to be used or brought to school until the products are available in a colour other than tan, the colour peanut butter.***

Appendix C

SECONDARY SCHOOL ENVIRONMENT ANAPHYLACTIC TEENAGER

(Resource: Anaphylaxis in Schools and Other Settings)

The management of allergens in high school is a balancing act between need for independence and a normal social life. Teens are at a higher risk for a severe allergic reaction, requiring greater vigilance.

TEEN WEBSITE – www.whyriskit.ca

Anaphylaxis Canada is providing the above website dedicated to providing resources and tools for pre-teens, teens and young adults living with severe allergies.

Secondary School Setting:

- Larger setting than the elementary school with interaction of many teachers and peers.
- Students are under less supervision.
- Limited supervision at lunchtime and the availability of leaving campus for lunch.

Secondary School Student:

- Sometimes inclined to let down their guard because they do not remember experiencing a reaction and begin to question whether they are still allergic.
- More vulnerable to peer influences.
- May deny their vulnerability and take greater risks.
- New friends. No longer with their elementary friends who knew about their allergies and what to do in an emergency.
- Part of the brain that makes decisions is the last to mature and may go through a period of very poor decision making (e.g. may engage in risky behaviour such as eating unsafe foods or neglecting to carry their medication).
- Desperate to fit in and be like everyone else.
  Fanny packs with auto-injectors are no longer acceptable attire; auto-injectors in jeans pockets are too conspicuous; going off with friends for an evening increases the risk of accidental exposure; the fear of being labeled “different” or “weird” may mean fewer people are aware of the possibility of a dangerous reaction; even symptoms themselves may be ignored because the adolescent fears becoming the center of attention.

Teens, parents and school staff should work together to agree to an anaphylaxis management strategy which protects the teen while respecting their need for privacy and their personal choice about how they want to educate others.

The secondary school student must be able to take on primary responsibility for allergen avoidance at school and in other environments.

Avoidance Strategies:

• Carry an epinephrine auto-injector at all times and know how to use it. If they have asthma, they should carry their asthma inhalers with their auto-injector.

- If they do not have their auto-injector with them they should not eat.
- Be cautious about eating food from the school cafeteria and ask about ingredients each time food is purchased.
- Eat off a napkin to avoid contact with potentially contaminated surfaces.
- Eat lunch with friends who are informed about their allergy and are able to help them if they have a reaction. These friends would know where their auto-injector is kept and when and how to use it.
- Seek help if they are being teased or bullied about their food allergy.
- Learn how to teach their new friends about their allergy
- Learn how to resist peer pressure.

School Role in reducing the risks for the secondary student:

- Identify students diagnosed with anaphylaxis (transitioning to new school)
- All staff to be informed of the identity of students at-risk for anaphylaxis.
- Prepare a Plan of Care for each student with anaphylaxis using the Board guide as a resource.
- Administration, teachers and coaches work together with the student and parents, to review their child's situation, (e.g. ensure that eating arrangements at school and on field trips are in place). Repeat process as necessary.
- Teachers need to know location of the student's 'second' EpiPen®.
- Do a 'spot check' as outlined in the Students Plan of Care to ensure that students at-risk have their auto injectors with them.
- Inform school community and students that the school is a 'minimized allergen environment' for peanuts and tree nuts and are not to be brought into the school.
- Inform students at risk that they have the support of school staff, and all complaints will be taken seriously.
- Encourage students to speak up immediately if they are aware of accidental exposure or an impending reaction, enabling staff to assist.
- Accessibility to a spare epinephrine auto-injector. Students may be at school until evening for extracurricular events and the second auto-injector is located in health room behind locked doors. Ensure you have a process for accessing the spare auto injectors with a key; remove the spare auto injectors and have at activity site, consider keeping a spare auto injector in the cafeteria, office, gymnasium etc. in case of an emergency.
- Principals/designate are recommended to meet with the contracted food service company and cafeteria manager, early in the school year, to review the contracted food service company's commitment to implement reduction strategies in school cafeterias for the avoidance of anaphylaxis allergens (e.g. peanuts and tree nuts).
- Communicate with foodservice staff. Identify anaphylactic students and check that food products for meals and snacks do not contain or 'may contain' peanuts, tree nuts.

Appendix D.1

SAMPLE LETTER TO PARENTS

Dear Parents/Guardians:

Re: STUDENTS TO SUPPLY TWO EPIPENS/ALLERJECTS – ONE TO BE KEPT IN A SECURE LOCATION IN THE SCHOOL

The Sudbury Catholic District School Board's protocol is for students to have two EpiPens®/Allerjects at the school. This protocol is based on the legislated obligation of parents/guardians to supply the lifesaving medication required by their child. The Board follows best practices as outlined by Anaphylaxis Canada.

Please refer to the following *'Frequently Asked Questions – Epinephrine'* from Anaphylaxis Canada. Source: http://www.anaphylaxis.ca/content/whatis/qa.asp

How many EpiPens®/Allerjects Should I Carry*?*
There should be at least two doses of epinephrine available at all times. A second dose could be required 5-15 minutes after the first if the reaction is continuing. The situation could occur where:

- The reaction is very severe, requiring a second dose
- The dose given is inadequate
- The injector is faulty
- The administration of the EpiPen®/Allerject was faulty
- Ambulance takes longer than 10-20 minutes to get to the location of the anaphylactic student.

To ensure your child has sufficient medication at school in case an emergency situation arises please assist us in providing two Epi Pens®/Allerjects. With thanks.

Sincerely

Principal

.....

Response from Parent/Guardian: (Return this portion of the letter to the School Principal)

I have read the information letter provided above.
☐ I will be providing my child with a second EpiPen®/Allerjects to be stored in a secure location at the school site.
☐ I will not be providing my child with a second EpiPen®/Allerjects to be stored in a secure location at the school site.

(Please discuss your reason(s) with the school principal)

_____	_____	_____
Name Printed	Signature	Date

Appendix D.2

SAMPLE LETTER TO PARENTS

Dear Parents/Guardians:

Re: STUDENTS CARRYING THEIR EPIPENS®

The Sudbury Catholic District School Board's protocol is for students (Grades 1-12) diagnosed with anaphylaxis and capable of doing so, to ***carry their EpiPen®/Allerject with them at all times***.
This protocol is based on the legislated requirements of Sabrina's Law on how the school can best fulfill its responsibility of responding to an emergency anaphylactic situation in the most efficient and safest way possible for the student.
The Board follows best practices as outlined by Anaphylaxis Canada. Please refer to the following '*Frequently Asked Questions - Epinephrine'* from Anaphylaxis Canada: Source: http://www.anaphylaxis.ca/content/whatis/qa.asp

"Where should I keep my EpiPen®/Allerject?"
Given the rapidity with which symptoms can develop and progress, epinephrine must be available immediately. For this reason, it is recommended that anaphylactic people carry their epinephrine with them at all times.

- In the school environment students move to different areas in the school (computer lab, library, gymnasium and to the outside playground during recesses. The only reliable consistent place for the lifesaving medication (epinephrine) is with the student.
- The amount of time it would take, for potentially any staff member (classroom teacher may not be there or not readily available), to access the EpiPen®/Allerject (located in the office/classroom/locker) when the child is at another location in the school (e.g. outside playground) could possibly place the child at a life-threatening risk.

Please assist us in having the lifesaving medication readily available, in an emergency situation, by having your child carry their EpiPen®/Allerject at all times.

Conditions for selection of a site for the location of the EpiPen®/Allerject OTHER than being carried by student:

1. Location of the EpiPen®/Allerject: must be in a readily accessible, secure but NOT locked location.
2. Waiver form: parents/guardians will receive a waiver form from the principal to be signed and placed in the student's Ontario School Record (OSR).

Sincerely,

Principal

Appendix D.3

SAMPLE: ANAPHYLAXIS LETTER RE: PEANUTS/TREENUTS TO SCHOOL COMMUNITY

Dear Parent/Guardian:

RE: MEDICAL DANGER – ANAPHYLAXIS

This letter is to inform you that there are students in our school with life threatening allergies to peanuts/tree nuts. Some students have such a high sensitivity to the peanut/tree nut protein that even a trace amount from a known peanut/nut product or a food product/item that has come in contact with a peanut/nut source (cross contamination) and is ingested can result in a life-threatening anaphylactic reaction. The most serious reaction being respiratory difficulties, blockage of the airways, which if not medicated immediately can lead to death.

THE LAW: AN ACT TO PROTECT ANAPHYLACTIC PUPILS

Sabrina's Law, An Act to Protect Anaphylactic Pupils received royal assent in June 2005 making it law for each school in Ontario to provide an anaphylaxis management plan that will reduce the risk of exposure to anaphylactic causative agents (e.g. peanuts/tree nut protein) in the classroom and common school areas.

AVOIDANCE AND PREVENTION

Products that contain or 'may contain' peanuts and tree nuts are not to be brought onto school site.

Our school's anaphylaxis plan conforms to Sabrina's Law and Sudbury Catholic DSB anaphylaxis policy. The plan is designed to ensure that students at risk are identified, strategies are in place to minimize the potential for accidental exposure and staff and key volunteers are trained to respond in an emergency situation.

To provide the minimized allergen environment required by the legislation, we need the support and cooperation of you, the parents/guardians and the school community. Students are asked to bring lunches and snacks free of peanuts and tree nuts and products that may contain peanuts/ tree nuts such as donuts, granola bars, etc.

We ask you to read food labels, checking of peanut/nut ingredients prior to sending them to school. If your child eats peanut butter at home before school, please ensure his/her hands are washed thoroughly before attending school. Truly, this is a life saving measure.

Look- a- Like Products to Peanut Butter

The Board is requesting that parents do not send their children to school with look-a-like products to peanut butter. The look-a-like products claim to be so close to peanuts in smell, taste and texture that you won't believe it's not peanut butter. As a result, it is difficult for teachers and children to differentiate between these products and peanut butter.

We appreciate your cooperation in keeping the look-a-like products at home and preventing the chance of a mix up between the two products – where the results could be life threatening.
If you have caregivers who provides your child(ren) with lunches or snacks we encourage you to share this information letter with them.

THANK YOU FOR YOUR SUPPORT

We realize this request may require added planning and effort on your part when packaging your child's lunch and snacks, however, we wish to express our sincere appreciation for your support and cooperation.

ACKNOWLEDGEMENT:
To ensure all parents/guardians have been made aware of life-threatening allergy to peanuts/tree nuts in our school we request you complete and return the response portion of this letter to your child's teacher.

Sincerely,

Principal

.....

MEDICAL DANGER –ANAPHYLAXIS ALERT TO PEANUTS AND TREE NUTS

This is to inform the school that I have read the Medical Danger – Anaphylaxis notice.

Parent name: _____
(Please Print)

Parent Signature: _____

Date: _____

(The principal may omit the tear off section and not require parental signature.)

PREVALENT MEDICAL CONDITION — ANAPHYLAXIS – PLAN OF CARE		
STUDENT INFORMATION		
Student Name _____	Date Of Birth _____	Student Photo
Ontario Ed. # _____	Age _____	
Grade _____	Teacher(s)/Courses _____	

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

KNOWN LIFE-THREATENING TRIGGERS

CHECK (✓) THE APPROPRIATE BOXES

❒ Food(s): _____ ❒ Insect Stings: _____

❒ Other: _____

Epinephrine Auto-Injector(s) Expiry Date(s): _____

Dosage: ❒ EpiPen® Jr. 0.15 mg ❒ EpiPen® 0.30 mg Location Of Auto-Injector(s): _____

_____

❒ Previous anaphylactic reaction: **Student is at greater risk.**
❒ Has asthma. **Student is at greater risk**. If student is having a reaction and has difficulty breathing, give epinephrine before asthma medication.
❒ Any other medical condition or allergy? _____

_____

DAILY/ROUTINE ANAPHYLAXIS MANAGEMENT

SYMPTOMS

A STUDENT HAVING AN ANAPHYLACTIC REACTION MIGHT HAVE ANY OF THESE SIGNS AND SYMPTOMS:

- **Skin system**: hives, swelling (face, lips, tongue), itching, warmth, redness.
- **Respiratory system** (breathing): coughing, wheezing, shortness of breath, chest pain or tightness, throat tightness, hoarse voice, nasal congestion or hay fever-like symptoms (runny, itchy nose and watery eyes, sneezing), trouble swallowing.
- **Gastrointestinal system** (stomach): nausea, vomiting, diarrhea, pain or cramps.
- **Cardiovascular system** (heart): paler than normal skin colour/blue colour, weak pulse, passing out, dizziness or light headedness, shock.
- **Other**: anxiety, sense of doom (the feeling that something bad is about to happen), headache, uterine cramps, metallic taste.

EARLY RECOGNITION OF SYMPTOMS AND IMMEDIATE TREATMENT COULD SAVE A PERSON'S LIFE.

Avoidance of an allergen is the main way to prevent an allergic reaction.

Food Allergen(s): eating even a small amount of a certain food can cause a severe allergic reaction.

Food(s) to be avoided: _____

Safety measures: _____

_____

Insect Stings: (Risk of insect stings is higher in warmer months. Avoid areas where stinging insects nest or congregate. Destroy or remove nests, cover or move trash cans, keep food indoors.)

Designated eating area inside school building _____

_____

Safety measures: _____

_____

Other information: _____

_____

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____

Special Instructions/Notes/Prescription Labels:

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.
✸This information may remain on file if there are no changes to the student's medical condition.

PLAN

This plan remains in effect for the 20___— 20___ school year without change and will be reviewed on or before: _____. (It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year).

Parent(s)/Guardian(s): _____ Date: _____
Signature

Student: _____ Date: _____
Signature

Principal: _____ Date: _____
Signature

PLAN REVIEW

Where there is no change in the child's condition or treatment strategy from the previous year(s), parents may authorize continuation of the protocol with initials below.

☐ There has been no change in condition or treatment strategy from previous year. Parent initial: _____

Date: _____

☐ There has been no change in condition or treatment strategy from previous year. Parent initial: _____

Date: _____

☐ There has been no change in condition or treatment strategy from previous year. Parent initial: _____

Date: _____

EMERGENCY PROCEDURES (DEALING WITH AN ANAPHYLACTIC REACTION)
ACT QUICKLY. THE FIRST SIGNS OF A REACTION CAN BE MILD, BUT SYMPTOMS CAN GET WORSE QUICKLY.
STEPS 1. Give epinephrine auto-injector (e.g. EpiPen®) at the first sign of a known or suspected anaphylactic reaction. 2. Call 9-1-1. Tell them someone is having a life-threatening allergic reaction. 3. Give a second dose of epinephrine as early as five (5) minutes after the first dose if there is no improvement in symptoms. 4. Follow direction of emergency personnel, including transport to hospital (ideally by ambulance), even if symptoms are mild or have stopped. The reaction could worsen or come back, even after treatment. Stay in the hospital for an appropriate period of observation as decided by the emergency department physician (generally about 4 - 6 hours). 5. Call emergency contact person; e.g. Parent(s)/Guardian(s).

Other Pertinent Information

CONSENT FORM
TO CARRY AND ADMINISTER MEDICATION/DISCLOSE PERSONAL INFORMATION

TO BE SIGNED BY PARENT/GUARDIAN UNLESS THE STUDENT IS 18 YEARS OF AGE OR OLDER

ADMINISTRATION OF MEDICATION

In the event of my child _____ experiencing a medical emergency, I consent to the administration of _____ (specify type of medication) by an employee of the Sudbury Catholic District School Board as prescribed by the physician and outlined in the Emergency Procedures of the Prevalent Medical Conditions Policy/Administrative Procedure.

PLEASE PRINT Student's Name: _____ Name of Parent/Guardian: _____ Signature of Parent/Guardian: _____ Signature of Student (if 18 or older): _____	Class/Teachers' Names: Date: _____ Date: _____

MAINTENANCE OF MEDICATION

I understand that it is the responsibility of my child _____to carry _____ (specify type of medication) on his/her person.

PLEASE PRINT Student's Name: _____ Name of Parent/Guardian: _____ Signature of Parent/Guardian: _____ Signature of Student (if 18 or older): _____ Name of Physician: _____	Class/Teachers' Names: Date: _____ Date: _____ Contact # _____

COLLECTION, DISCLOSURE AND USE OF PERSONAL INFORMATION

Authorization for the collection and maintenance of the personal information recorded on the Prevalent Medical Conditions form is the Municipal Freedom of Information and the Protection of Privacy Act. Users of this information should be directed by the principal of the school.

OPTIONAL:

Additionally, I further consent to the disclosure and use of the personal information collected herein to persons, including persons who are not the employees of the Sudbury Catholic District School Board through the posting of photographs and medical information of my child (Plan of Care/Emergency Procedures) in the following key locations:

☐ Classroom	☐ Staffroom	☐ Lunchroom
☐ Office	☐ Gym	☐ Learning Commons/Library
☐ Other: _____	☐ Other: _____	

and through the provision of personal information contained herein to the following persons who are not employees of the Board: please check (✓) all applicable boxes

☐ Food Service Providers	☐ Child Care Providers
☐ School Volunteers in regular direct contact with child	☐ Other: _____

Signature of Parent/Guardian: _____	Date: _____
Signature of Student (if 18 or older): _____	Date: _____
Signature of Principal: _____	Date: _____

We release the Sudbury Catholic District School Board, its employees and agents from any and all liability for loss, damage or injury, howsoever caused to my/our child's person, or property, or to me/us as a consequence, arising from administering the interventions, failing to correctly administer the interventions and/or failing to administer any intervention listed in Epilepsy/Seizure Disorder Student Plan of Care.

Signature of Parent/Guardian: _____	Date: _____
Signature of Student (if 18 or older): _____	Date: _____

PLEASE NOTE THIS CONSENT EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR

This information is collected pursuant to s. 170 and s.265(1)i) of the Education Act, R.S.O. 1990, c. E-2 and s.28(2), 29, 30, 31,32 and 33 of the Municipal Freedom of Information and Protection of Privacy act, R.S.O. 1990, c. M-56: and the Personal Health Information Protection Act, 2004, S.O. 2004, c.3, Sch. A.
If you have any questions regarding your child's personal information, please contact the Principal of your child's school.

AT-A-GLANCE Medical Condition IDENTIFICATION

Student Name	Grade	Medical Condition	Picture (If avaialble)

MEDICAL INCIDENT RECORD FORM						
Student Name	Time of Incident	Length of Incident	Events before Incident	Description of Incident	Events after Incident	Date/Time Parent/Gaurdian Contacted

SUDBURY CATHOLIC DISTRICT SCHOOL BOARD

Introduction

This Asthma Protocol addresses the components of Ministry of Education Policy/Program Memorandum 161 Supporting Children and Students with Prevalent Medical Conditions (Anaphylaxis, Asthmas, Diabetes, and/or Epilepsy) in Schools.

Rationale for an Asthma Protcol

Uncontrolled asthma may limit children's learning opportunities and can cause many nights of interrupted sleep, several days of limited activity, and disruptions in normal activities of life. All these factors influence how children behave and learn at school.

What is Asthma?

Asthma is a chronic inflammatory disease of the airways in the lungs. Inflammation in the airways makes the lungs more sensitive to things/substances in our environment termed 'asthma triggers'.
When people with asthma are exposed to their triggers three things may happen that narrow the airways:

- contraction (squeezing) of the airway muscles
- more airway inflammation, and extra mucus production
- narrowing of the airways can cause difficulty breathing, coughing and wheezing (whistle sound)

Sudden narrowing of the airways produce what is often called an 'attack of asthma' or an asthma flare-up.

Symptoms

- Constant coughing
- Trouble breathing
- Chest tightness (like a tight band around the chest)
- Wheezing (whistling sound in the chest)
- Student may also be restless, irritable and/or tired

The symptoms can be reversed with medication and by reducing exposure to environmental triggers. Not every person will experience all of these symptoms listed. Often a cough may be the only sympton experienced.

What is an Asthma Trigger?

An asthma trigger is anything in the environment that causes or provokes asthma symptoms (cough, wheeze, difficulty breathing). Common triggers include viral infections (common colds); allergies (animals, house dust mites, dust, pollen, and moulds); fumes (paints, and eligible markers, perfumes, cleaning products and glue); extremes of temperature (cold or hot and humid); exercise; and crying or laughing. Most children with asthma have more than one trigger. However, the triggers and the degree of asthma symptoms differ for each person with asthma.

Asthma Medication

In general, asthma medications work in one or two ways to control asthma. They work either by controlling or preventing the information and mucous production, or by relieving the muscle chart tightness around the airways.

Controller Medication (Flovent, Advair, Qvar, Pulmicort, Alvesco, Zenhale, etc.)

- Used daily, before and after school at home, to prevent asthma attacks
- Decreases and prevents swelling of the airways

- Can take days to weeks of daily use to work effectively
- Various colours (orange, purple, brown, red)

Reliever Medication (Ventolin/Salbutamol, Bricanyl, etc.)

- Used to relieve symptoms of asthma. Also called the 'rescue' inhaler, usually blue in colour)
- Needs to be quickly accessible at all times
- Provides relief quickly, within minutes
- Relaxes the muscles of the airways
- Taken only when needed

Anaphylaxis and Asthma

People with asthma who are also diagnosed with anaphylaxis are more susceptible to severe breathing problems when experiencing an anaphylactic reaction. It is extremely important for asthmatic students to keep their asthma well controlled. In cases where an anaphylactic reaction is suspected, but there is uncertainty whether or not the person is experiencing an asthma attack, epinephrine should be used first**.** Epinephrine can be used to treat life-threatening asthma attacks as well as anaphylactic reactions. Asthmatics who are at risk of anaphylaxis should carry their asthma medications (e.g. puffers/inhalers) with their epinephrine auto-injector (e.g. EpiPen®).

What is Exercise Induced Asthma (EIA)?

When students participate in physical activity, it is common to switch from breathing through the nose to mouth breathing and to breathe at a much faster rate. This can cause cooling and drying of the sensitive airways. This cooling and drying effect causes the airways to narrow resulting in asthma symptoms. Exercise-induced asthma may present itself during or after physical activity. It is more common when activities are done in cold environments, during high pollen or pollution count days, or when the student has an underlying cold/chest infection**.** Most cases of exercise-induced asthma can be treated by taking your medication as prescribed by your health care professional. Consult with your doctor if you need to take your reliever before and/or after exercise. For more information about EIA visit www.lung.ca/asthma/exercise

Duty of Care

Ryan's Law, 2015 (Ensuring Asthma Friendly Schools)

https://www.ontario.ca/laws/statute/15r03
Requires that every school board establish and maintain an asthma policy, which must include, among other things, strategies to reduce risk of exposure to asthma triggers; a communication plan for the dissemination of information on asthma, regular training on recognizing asthma symptoms and managing asthma exacerbations. It is a requirement that every school principal develop an Plan of Care for each pupil who has asthma; and a requirement that every school principal maintains a file for each pupil.

Education Act

Education Act 265 (1): Duties of Principals

j) care of pupils and property – to give assiduous attention to the health and comfort of the pupils

Education Act, Regulations: Reg. 298, S20: Duties of Teachers

g) ensure that all reasonable safety procedures are carried out in course and activities for which the teacher is responsible

Common Law Duties Owed by Teachers

To assist or allow a student to seek medical attention as a careful parent would. The board's liability policy provides coverage for employees acting within the scope of their duties with the board. Best, all school staff who administer first aid to a student who is suffering from an asthma attack within the school or during a school activity, are covered.

Communication of Information on Asthma

The board public webpage offers resources that include information about asthma that can be shared with all parents/guardians, students, employees, volunteers, coaches and other persons who have direct contact with a student with asthma. School administrators are asked to consider these links in school newsletters, on the school website or in other pertinent areas, or in a letter home to all parents/guardians at the beginning of the school year.

This information is intended to assist people in understanding how to reduce exposure to asthma triggers, and how to recognize when asthma is worsening and how to manage asthma symptoms exacerbations.

The school principal/designate shall work with staff and families to help ensure that an asthma friendly school environment exists that is safe and supportive for all students. The Ontario Phsycial and Health Education Association (Ophea) Manual – Creating Asthma Friendly Schools is a useful resource.

Identification

Have a process in place where children with an asthma condition are identified to the school system by parents/guardians and are requested to supply information on the asthma condition.

- **Students, new to the school, during registration**

Question during intake meeting specifically asking whether or not child is asthmatic (or has any other medical conditions) Asthma Student Plan of Care provided to parent/guardian for further information regarding asthma triggers, etc.

- **Students presently registered at school**

At the beginning of each school year, the school principal/designate shall have a process in place of requesting parent/guardian/adult student to identify if there is a new diagnosis of asthma (throughout the school year)

- **Ensure student's medical condition(s) are entered** into the board's student database system.
- **Principals will ensure the creation/revision** of the Student Plan of Care and keep a copy of any prescriptions

Development of Asthma Student Plan of Care

The parent/guardian in consultation with the principal shall create, review and update the plan of care during September, or on the date as requested by the school administrator.

The plan shall be reviewed by the principal/designate in consultation with the parent/guardian/adult student following the Asthma Protocol, on an annual basis or when there is a change in the child's condition or changes to the prescribed medication. Where appropriate the classroom teacher is to be part of the information sharing process.

The child's asthma triggers are to be identified and avoidance strategies are to be developed and implemented.

Location of Inhaler Medication

- Parent/guardian permission for student to carry their reliever inhaler is located in the Student Plan of Care
- For students that require assistance with their inhaler(s) (i.e. identified on the Asthma

Student Plan of Care) inform and train appropriate staff. Training can be done by parents/guardians of the student, or request the parents contact the child's health care provider for reference to LHIN.

- Students up to 16 years of age who have parental permission and who are capable of doing so, are to carry their reliever inhaler at all times (e.g. to and from school, when moving classroom locations, breaks - recess and noon time, all field trips, evacuation procedures and lockdowns)
- Students in kindergarten: classroom teacher is responsible for housing the reliever inhaler and developing a process for having it accessible for the student at all times.
- Where age, people capacity (intellectual/physical), activity, or location prevents the safe carrying; the reliever inhaler must be located in proximity to the student for ready access (e.g. physical activities - indoor/outdoor)
- Where outdoor seasonal triggers are not present, or do not affect the student's asthma, the reliever inhaler, under parental permission as stated in the Asthma Student Plan of Care, does not have to be carried outside and can remain in the student's classroom.
- Where student has a second or spare reliever inhaler at the school, ensure that it is stored under proper conditions, as per the manufacturer's requirements, and inform teachers/staff who have direct contact with student of its location and identify its location on the Plan of Care.

Activity and Students with Asthma

Medication Prior to Activty

The Asthma Student Plan of Care must indicate if a student is to take the reliever medication prior to physical activity. Have student use reliever as per doctor's directions.

Asthma Symptons Prior to Activity

If the student is already experiencing asthma symptoms such as, coughing or difficulty breathing, they should not participate in physical activity as this can lead to a severe asthma attack. A reliever/rescue inhaler should be used to relieve the symptoms.

Warm up and cool downs

A good warm up and cool down before and after physical activity may assist in preventing the development of asthma symptoms:

- Before vigorous physical activity, begin your activity with a progressive warm up. The purpose is to warm both the body and the airways in preparation for the activity (e.g. begin by light walking and progress gradually to a jog).
- The intensity of the activity should start at a low level and gradually increase to develop exercise tolerance.
- End your lesson with a cool down period. The purpose is to gradually bring the heart rate down slowly to a resting rate and reduce the chance of asthma symptoms occurring after the exercise.

Asthma symptoms occurring after physical activity begins

If symptoms occur after physical activity begins, have the student stop the activity. A reliever inhaler may be needed to fully relieve symptoms. Once the student is fully recovered, s/he may resume normal school activity, including physical activity.

A fully recovered student:

- Will breathe at a normal rate.
- Will not be wheezing/coughing.
- Will be able to carry on a conversation without any breaks.

Identifying and Managing Triggers for Phsycial Activity

Outdoor Triggers

- **Cold Air**
  - Some students with asthma may require something to cover their mouth and nose (e.g. a scarf or neck warmer). This can help to add warmth and moisture to cold dry air and potentially reduce the chance of asthma symptoms occurring.
  - Choose well ventilated indoor sites on days with extreme temperatures.

- **Air Quality, Smog**
  - Find out about air quality and smog alerts by checking local weather forecasts. www.airqualityontario.com provides up to date information on daily forecasts.
  - Choose well-ventilated indoor sites on days when the air quality is poor.

- **Pollen, Trees, Leaves**
  - If possible, try to avoid playing on freshly cut grass.
  - Pollen count reports can be found on local weather channels https://www.theweathernetwork.com/ca
  - Participate in physical activity outdoors after 10 a.m. if possible when pollen counts are lower.

Indoor Triggers (Classroom, Gymnasiums, and Multipurpose Rooms)

When activities take place indoors take precautions to minimize or eliminate the following triggers that may cause asthma symptoms: strong smells from markers, paints, cleaning products and perfumes; chalk, dust, and animals.

- If carpet is used, use a throw rug so that it can easily be washed
- Report any mould concerns to your principal
- Remove any animals from classroom
- Ensure a no-perfume policy is in place in your work environment
- Choose scent-free products when possible – e.g. unscented markers, art supplies, etc.
- Use dry-erase boards with scent-free markers more often
- Keep windows closed during high pollen count days

Indicators that Asthmas is NOT in Control

- **Communication to Parent/Guardians of Students with Asthma**
-

  Following the Canadian Thoracic Society – Canadian Respiratory Guidelines for the Manaemgment of Asthma 2012.

  - **Elementary School Students**
    If elementary school staff observe either one or both of the following indicators that the child's asthma is not in control school staff are to inform parent/guardians
    Indicators that asthma is not in control:
    - Reliever medication had to be taken for a second time (twice) in a 4-hour period.
    - Reliever medication had to be used more than 4 times in a week.
  - **Secondary school students:**

  Due to the nature of secondary school programs the same teacher is not with the student during the whole day to observe indicators. It is the student's responsibility to inform parents of when their reliever inhaler is used. When/if a teacher does observe the indicators, the teacher will remind the student to inform their parent/guardian.

Instructions for Managing Asthma Attacks

Milder Symptoms	**Asthma Emergency:** If mild symptoms get worse or do not improve within 5-10 minutes.
If any of the following **symptoms** occur: • Constant coughing • Trouble breathing • Chest tightness (like a tight band around the chest) • Wheezing (whistling in chest)	if any of these **symptoms** occur: • Breathing is difficult and fast • Cannot speak more than 5 words between breaths • Lips or nail beds are blue or gray • Skin on neck or chest sucked in with each breath • Requests a doctor or ambulance or asks to go to the hospital; **OR** • You have any doubt about the student's condition.
Action: • Immediately have the student use/administer reliever inhaler as directed by medical doctor (refer to medication label). • If there is an identifiable trigger, remove the student from the trigger. • Have the student in an upright position e.g. sit up with arms resting on a table. • Advise the student to breathe slowly and deeply. • Do NOT have student breathe into a bag or lie down. • If student fully recovers**,** participation in activities may resume.	**ACTION:** **Step 1: Call 911 for an ambulance** – Follow 911 communication protocol with emergency responders. **Step 2: Immediately** use reliever inhaler Continue to use reliever inhaler every **5-15 minutes** until medical help arrives. While waiting for medical help to arrive: • Have the person sit up with arms resting on a table (do not have person lie down unless it is a life-threatening allergic event) • Stay calm, reassure the person and stay by their side. • Contact parents/caregivers, as soon as possible.

Note: School administrators consider simulating and asthma emergency, with all staff, similar to a fire drill, to review and check to see that all elements of the school's emergency protocol are in place and everyone knows their role.

Field Trips and Students with Asthma (Day Trips, Overnight Trips, Extensive Trips, Exchange Programs)

- **Process in place to identify students with asthma** participating on the trip along with their asthma triggers and required medication
- **In order to participate** on a field trip **a student diagnosed with asthma must carry their reliever inhaler at all times** or during physical activities **have the inhaler immediately accessible**.
- **Trip site and activities are to be checked to identify potential allergens.** Where possible a pre-activity inspection of the site and activities by the in-charge teacher to investigate for potential asthma triggers. Common triggers to think about include exposure to animals, mould, strong smells, extremes of heat and cold and strenuous activity.
- **Communicate with the child's parents/guardians** during the initial planning stages of the trip informing them of the destination, mode of travel and activities students are to participate in. This will allow for parent/guardian input in the school developing a clear set of expectations and accommodations to meet their child's medical needs on the trip. Knowing the trip expectations and accommodations the parents will be able to provide an informed decision as to their child's participation. You may consider inviting parent on the trip as a supervisor.

- For overnight, extensive or exchange programs parents **are to be informed** that they must:
    - Provide adequate supply of medications (controller and reliever) and additional required equipment. They may want to include back up (or second) inhalers, in the case of loss.
    - Provide detailed instructions regarding the use of the medications that include the dose and time of day or indications for the use of the medication.
- **Tour operator and/or activity provider**
    - In-charge teacher is to identify the students with asthma and their triggers.
    - Request operator to provide you with their accommodations for students with asthma.
    - Compared tour operator's plans for accommodations with school board expectations for accommodations for one of its students.
    - Adjust operator's accommodation plans accordingly to the needs of the student. Follow the plans wherever there is a higher standard.
    - If trip provider does not have a pre-existing plan for the student's medical condition, develop one of your own based on school board expectations and parent input and provide the operator with a copy.
    - Based on list of accommodations for the student the tour operator must provide:
        - Safe accommodations during travel to destination
        - Safe facilities, safe programming, safe foods at the destination
        - Ready access to a doctor, clinic or hospital at destination site
- **An emergency action plan for asthma** on the trip must be prepared by the in-charge teacher and communicated to all staff and volunteers on the trip.
- **Student forms on the trip –** copy of the student's Asthma Plan of Care along with trip accommodations, where appropriate, are to be taken on the trip.
- **Grouping of student(s)**: student is to assigned to a group with staff member who is knowledgeable about managing and responding to an asthma attack.
- **Buddy system:** In situations where the teacher/supervisor is providing 'in the area supervision' the teacher is to assign a buddy to the student. The 'buddy's' responsibility is to assist the student and to access the teacher supervisors in case of an emergency.
- **A suitable means of communication** (e.g. cell phone) to be taken on the trip and/or an easily accessible phone is available at the site. Ensure that you have the correct and proper change if using payphones.
- **Trip supervisors to meet students** ahead of time who have asthma and provide the following information:
    - Students agree to tell trip supervisor:
        - What triggers their asthma
        - If they anticipate having trouble with their asthma on the trip
        - When their asthma is bothering them
        - Inhalers must be labelled with the student's name
        - Inform trip supervisor/teacher supervisor when you use your inhaler more than twice in a 4-hour period
        - Stress to students that if they have an asthma attack, do not (never) go off alone or remove self to a secluded area, like the washroom. Tell a supervising teacher, volunteer or classmate about having trouble breathing and need help. In order to help, people need to know whereabouts and that help is needed.

PREVALENT MEDICAL CONDITION — ASTHMA Plan of Care		
STUDENT INFORMATION		
Student Name _____	Date of Birth _____	Student Photo
Ontario Ed. # _____	Age _____	
Grade _____	Teacher(s) _____	

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2			
3.			

KNOWN ASTHMA TRIGGERS				
CHECK (✓) ALL THOSE THAT APPLY				
❒ Colds/Flu/Illness	❒ Change in Weather	❒ Pet Dander	❒ Strong Smells	
❒ Smoke (e.g., tobacco, fire, cannabis, second-hand smoke)	❒ Mold	❒ Dust	❒ Cold Weather	❒ Pollen
❒ Physical Activity/Exercise	❒ Other (Specify)_____			
❒ At Risk for Anaphylaxis (Specify Allergen) _____				
❒ Asthma Trigger Avoidance Instructions: _____ _____				
❒ Any Other Medical Condition or Allergy? _____ _____				

DAILY/ ROUTINE ASTHMA MANAGEMENT

RELIEVER INHALER USE AT SCHOOL AND DURING SCHOOL-RELATED ACTIVITIES

A reliever inhaler is a fast-acting medication (usually blue in colour) that is used when someone is having asthma symptoms. The reliever inhaler should be used:

❒ When student is experiencing asthma symptoms (e.g., trouble breathing, coughing, wheezing).

❒ Other (explain): _____

Use reliever inhaler _____ in the dose of _____
(Name of Medication) (Number of Puffs)

Spacer (valved holding chamber) provided? ❒ Yes ❒ No

Place a (✓) check mark beside the type of reliever inhaler that the student uses:
❒ Airomir ❒ Ventolin ❒ Bricanyl ❒Other (Specify) _____

❒ Student requires assistance to **access** reliever inhaler. Inhaler must be **readily accessible**.

Reliever inhaler is kept:
- ❒ With _____ – location: _____ Other Location: _____
- ❒ In locker # _____Locker Combination: _____

❒ Student **will carry** their reliever inhaler **at all times** including during recess, gym, outdoor and off-site activities.

Reliever inhaler is kept in the student's:
- ❒ Pocket
- ❒ Backpack/fanny Pack
- ❒ Case/pouch
- ❒ Other (specify): _____

Does student require assistance to **administer** reliever inhaler? ❒ Yes ❒ No

❒ Student's **spare** reliever inhaler is kept:
- ❒ In main office (specify location): _____ Other Location: _____
- ❒In locker #: _____Locker Combination: _____

CONTROLLER MEDICATION USE AT SCHOOL AND DURING SCHOOL-RELATED ACTIVITES

Controller medications are taken regularly every day to control asthma. Usually, they are taken in the morning and at night, so generally not taken at school (unless the student will be participating in an overnight activity).

Use/administer _____ In the dose of _____ At the following times: _____
(Name of Medication)

Use/administer _____ In the dose of _____ At the following times: _____
(Name of Medication)

Use/administer _____ In the dose of _____ At the following times: _____
(Name of Medication)

EMERGENCY PROCEDURES

IF ANY OF THE FOLLOWING OCCUR:

- Continuous coughing
- Trouble breathing
- Chest tightness
- Wheezing (whistling sound in chest)

(* Student may also be restless, irritable and/or quiet.)

TAKE ACTION:

STEP 1: Immediately use fast-acting reliever inhaler (usually a blue inhaler). Use a spacer if provided.

STEP 2: Check symptoms. Only return to normal activity when all symptoms are gone.
If symptoms get worse or do not improve within 10 minutes, this is an **EMERGENCY!**

Follow steps below.

IF ANY OF THE FOLLOWING OCCUR:

- Breathing is difficult and fast
- Cannot speak in full sentences
- Lips or nail beds are blue or grey
- Skin or neck or chest sucked in with each breath

(*Student may also be anxious, restless, and/or quiet.)

THIS IS AN EMERGENCY:

STEP 1: IMMEDIATELY USE ANY FAST-ACTING RELIEVER (USUALLY A BLUE INHALER). USE A SPACER IF PROVIDED.
Call 9-1-1 for an ambulance. Follow 9-1-1 communication protocol with emergency responders.

STEP 2: If symptoms continue, use reliever inhaler every 5-15 minutes until medical attention arrives.

While waiting for medical help to arrive:

- ✓ Have student sit up with arms resting on a table (do not have student lie down unless it is an anaphylactic reaction).
- ✓ Do not have the student breathe into a bag.
- ✓ Stay calm, reassure the student and stay by his/her side.
- ✓ Notify parent(s)/guardian(s) or emergency contact.

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____

Special Instructions/Notes/Prescription Labels:

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.
✸This information may remain on file if there are no changes to the student's medical condition.

PLAN

This plan remains in effect for the 20___— 20___ school year without change and will be reviewed on or before: _____. (It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year).

Parent(s)/Guardian(s): _____ Date: _____
Signature

Student: _____ Date: _____
Signature

Principal: _____ Date: _____
Signature

PLAN REVIEW

Where there is no change in the child's condition or treatment strategy from the previous year(s), parents may authorize continuation of the protocol with initials below.

☐ There has been no change in condition or treatment strategy from previous year. Parent initial: _____

Date: _____

☐ There has been no change in condition or treatment strategy from previous year. Parent initial: _____

Date: _____

☐ There has been no change in condition or treatment strategy from previous year. Parent initial: _____

Date: _____

CONSENT FORM
TO CARRY AND ADMINISTER MEDICATION/DISCLOSE PERSONAL INFORMATION

TO BE SIGNED BY PARENT/GUARDIAN UNLESS THE STUDENT IS 18 YEARS OF AGE OR OLDER

ADMINISTRATION OF MEDICATION

In the event of my child _____ experiencing a medical emergency, I consent to the administration of _____ (specify type of medication) by an employee of the Sudbury Catholic District School Board as prescribed by the physician and outlined in the Emergency Procedures of the Prevalent Medical Conditions Policy/Administrative Procedure.

PLEASE PRINT
Student's Name: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Signature of Student (if 18 or older): _____

Class/Teachers' Names:

Date: _____

Date: _____

MAINTENANCE OF MEDICATION

I understand that it is the responsibility of my child _____to carry _____ (specify type of medication) on his/her person.

PLEASE PRINT
Student's Name: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Signature of Student (if 18 or older): _____

Name of Physician: _____

Class/Teachers' Names:

Date: _____

Date: _____

Contact # _____

COLLECTION, DISCLOSURE AND USE OF PERSONAL INFORMATION

Authorization for the collection and maintenance of the personal information recorded on the Prevalent Medical Conditions form is the Municipal Freedom of Information and the Protection of Privacy Act. Users of this information should be directed by the principal of the school.

OPTIONAL:

Additionally, I further consent to the disclosure and use of the personal information collected herein to persons, including persons who are not the employees of the Sudbury Catholic District School Board through the posting of photographs and medical information of my child (Plan of Care/Emergency Procedures) in the following key locations:

☐ Classroom	☐ Staffroom	☐ Lunchroom
☐ Office	☐ Gym	☐ Learning Commons/Library
☐ Other: _____	☐ Other: _____	

and through the provision of personal information contained herein to the following persons who are not employees of the Board: please check (✓) all applicable boxes

☐ Food Service Providers	☐ Child Care Providers
☐ School Volunteers in regular direct contact with child	☐ Other: _____

Signature of Parent/Guardian: _____	Date: _____
Signature of Student (if 18 or older): _____	Date: _____
Signature of Principal: _____	Date: _____

We release the Sudbury Catholic District School Board, its employees and agents from any and all liability for loss, damage or injury, howsoever caused to my/our child's person, or property, or to me/us as a consequence, arising from administering the interventions, failing to correctly administer the interventions and/or failing to administer any intervention listed in Asthma Management Student Plan of Care.

Signature of Parent/Guardian: _____	Date: _____
Signature of Student (if 18 or older): _____	Date: _____

PLEASE NOTE THIS CONSENT EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR

This information is collected pursuant to s. 170 and s.265(1)i) of the Education Act, R.S.O. 1990, c. E-2 and s.28(2), 29, 30, 31,32 and 33 of the Municipal Freedom of Information and Protection of Privacy act, R.S.O. 1990, c. M-56: and the Personal Health Information Protection Act, 2004, S.O. 2004, c.3, Sch. A.
If you have any questions regarding your child's personal information, please contact the Principal of your child's school.

AT-A-GLANCE Medical Condition IDENTIFICATION

Student Name	Grade	Medical Condition	Picture (If avaialble)

MEDICAL INCIDENT RECORD FORM						
Student Name	Time of Incident	Length of Incident	Events before Incident	Description of Incident	Events after Incident	Date/Time Parent/Gaurdian Contacted

SUDBURY CATHOLIC DISTRICT SCHOOL BOARD

PREAMBLE

This Diabetes Protocol addresses the components of Ministry of Education Policy/Program Memorandum 161 Supporting Children and Students with Prevalent Medical Conditions (Anaphylaxis, Asthmas, Diabetes, and/or Epilepsy) in Schools.

Rationale For a Diabetes Protocol

The Diabetes Protocol is an information and resource manual to be used by school staff to assist in managing and supporting students diagnosed with diabetes (both type 1 or type 2) so students can learn in an environment that is safe and supported.

The goal of this protocol is to

- Enable students with diabetes to participate equitably and inclusively in all school activities as outlined in their Plan of Care.
- Educate school personnel about diabetes, its causes, symptoms, emergency treatments
- Outline responsibilities for the care and management of students with diabetes
- Provide strategies on how to support the student in the management of their diabetes in the school setting and at school sponsored activities off school site
- Minimize anxiety on the part of parents and school personnel by outlining appropriate steps to minimize risk and ensure the safety, health and success of students with diabetes while they are under school supervision

The ultimate responsibility for diabetes management rests with the family and the child. The ultimate goal of diabetes management within the school setting is to have a child be independent in managing their diabetes. The school role is to provide **support** as the child moves from dependence to independence and to create a supportive environment in which their transition can occur. This independence includes a specific management of diet, activity, medication (insulin) and blood sugar testing, as required. Independence of care also include the development of self-advocacy skills and a circle of support among persons who understand the disease and can provide assistance as needed.

GUIDELINES

What is Diabetes?

- **Diabetes Mellitus**: Insulin is an essential body requirement and without it, carbohydrate (starch and sugars) in the food we eat cannot be converted into the energy (called glucose) required to sustain life. Failure of insulin production leads to a condition called diabetes mellitus. There are two major types of diabetes - type 1 and type 2.

  Type 1 Diabetes develops when the body's immune system destroys the insulin producing cells of the pancreas. Presently there is no cure for type 1 diabetes. Management of this conditions is done through careful meal planning, regular activity and taking insulin injections.

  Type 2 Diabetes in children/youth: develops when the pancreas does not produce enough insulin, and/or the body does not properly use the insulin it makes. Type 2 is presently affecting more of our children and youth and is linked to lifestyle factors such as obesity and sedentary living. Type 2 is a preventable and treatable disease by controlling weight e.g. exercising regularly and eating a healthy diet. Where diet and exercise is not enough to control disease it may be necessary to treat with oral medication or insulin.

Type 1 Diabetes – The Balancing Act: Insulin, Food, Exercise
The treatment of type 1 diabetes can be viewed as a balancing act. Food, on one side, increases the amount of glucose in the blood. Exercise and insulin on the other hand, lower the blood glucose level by allowing the glucose to be used for energy.

Three main variables of control: insulin, food and exercise:

- **insulin** lowers blood sugars and must be taken by injection, or by wearing an insulin pump. Younger students do not usually take insulin injections at school.
- **Food** raises blood sugars. The student must eat measured amounts of carbohydrates at certain times of the day in order to balance the injected insulin.
- **Exercise** usually lowers blood sugars. The student may take some juice or a snack before an activity to prevent blood sugar from going too low.

Activities that help keep blood sugars in a healthy range

- **Eat:**
    - Food is like a medicine to the student with diabetes. Eating is a key part of managing diabetes. To avoid a low blood sugar, it is important to:
        - Allow student to eat when they need to.
        - Encourage student to eat all the food as outlined in their prescribed diet and/or as prepared by their parents.
        - Provide sufficient time for the child to eat all the food (meal/snack). Supervising teacher to consider adjusting time requirements for eating.
        - When appropriate, the classroom teacher is to communicate with parent when there will be changes to the daily route routine (e.g. if snacks or activity times will be changed, extra activity, or an extended day (e.g. extra help, detention, sport activities)), so parents can ensure the child has additional snacks or make an insulin change to reduce the chance of a low blood sugar.
        - Food is not to be used as an incentive or reward to students.
- **Check Blood Sugar**:
    - The student will usually check their blood sugar level using a special meter, before eating a snack/meal, and/or whenever they feel unwell.

Conditions of Type 1 and Type 2 diabetes:

- Low blood sugar-Hypoglycemia
- High blood sugar-Hyperglycemia

Low Blood Sugar - Hypoglycemia
When supporting a student with type 1 diabetes the emergency situation you are most likely to encounter is low blood sugar also known as hypoglycemia reaction or insulin shock.
A low blood sugar means that the level of sugar present in the blood is inadequate for the brain to function properly. Every student will have their own unique signs and symptoms of feeling 'low' (refer to the Student's Plan of Care).
The key to keeping a student safe is managing a low blood sugar as soon as it is detected.

High Blood Sugar- Hyperglycemia

Hyperglycemia occurs when people with diabetes have too much sugar in their bloodstream. The three main symptoms of high blood sugar levels are increased urination, increased thirst and increased hunger. Testing blood sugar levels will help in managing hyperglycemia.

The Sick Child
Children with diabetes are no more susceptible to infection or to illness than their classmates. They do not need to be in a special 'health class' at school. Their attendance record should be normal.

When children with diabetes become ill with the usual fevers and other childhood sicknesses the blood glucose balance is likely to be upset. Careful monitoring with blood glucose and urine testing, a fluid diet and extra insulin may be required. Such illness management is the responsibility of the parent, not staff. When children with diabetes become ill at school, the parents should be notified immediately so that they can take appropriate action.

Vomiting and inability to retain food and fluids are serious situations, since food is required to balance the insulin.
If the child vomits, contact the parents immediately. If unable to reach the parents call 911. Inform EMS the child has diabetes.

Interference with school activities
When blood sugar levels are outside the target range (i.e. hypoglycemia or hyperglycemia) the student's learning, behaviour and participation may be affected.
Hyperglycemia and hypoglycemia may also affect the students' behavior. However, having diabetes is not an excuse for inappropriate behavior.

Duty of Care
This Diabetes Protocol for school administrators, teachers and other employees has been developed to meet the requirements of:
Education Act:
Education Act 265 (1): Duties of Principals
j) care of pupils and property – to give assiduous attention to the health and comfort of the pupils

Education Act, Regulations: Reg. 298, S20: Duties of Teachers
g) ensure that all reasonable safety procedures are carried out in courses and activities for which the teacher is responsible

Common Law Duties Owed by Teachers:
To assist or allow a student to seek medical attention as a 'careful parent' would. The board's liability policy provides coverage for employees acting within the scope of their duties with the board. Best, all school staff who administer first aid to a student who is suffering from diabetic emergency within the school or during a school activity, are covered.

Syringe Injections
Presently the SCDSB protocol for administering syringe ejections is that the school staff do NOT administer insulin or glucagon injections.

Communication of Information on Diabetes
The Board public webpage offers resources that include information about diabetes that can be shared with all parents/guardians, students, employees, volunteers, coaches and other persons who have direct contact with a student with diabetes. School administrators are asked to consider including links in school newsletters, on the school website or and other pertinent areas.
This information is intended to assist people in understanding diabetes.
The school principal/designate shall work with staff and students to help ensure that a diabetes friendly school environment exists that is safe and supportive for all students.

Identification
Have a process in place where children with diabetes are identified to the school system by parents/guardians and requested to supply information on the condition.

- **Students, new to the school, during registration**
  Question during intake meeting specifically asking whether or not child is diabetic (or has any other medical conditions). Diabetes Student Plan of Care provided to parent/guardian for further information regarding diabetes triggers, etc.

- **Students presently registered at school**
  At the beginning of each school year, the school principal/designate shall have a process in place of requesting parent/guardian/adult student to identify if there is a new diagnosis of diabetes (throughout the school year)
- **Ensure students medical condition(s) are entered** into the boards student database system.
- **Principals will ensure the creation/revision** of the Student Plan of Care and keep a copy of any prescriptions

Development of the Diabetes Student Plan of Care
The parent/guardian in consultation with the principal shall create, review and update the Plan of Care during September, or on the date as requested by the school administrator.

The plan shall be reviewed by the principal/designate in consultation with the parent/guardian/adult student following the Diabetes Protocol, on an annual basis or when there is a change in the child's condition or changes to the prescribed medication. Where appropriate the classroom teacher is to be part of the information sharing process.

The child's diabetes symptoms are to be identified and management strategies are to be developed and implemented.

Management of Type 1 or Type 2 diabetes through self-monitoring

Blood Sugar Testing
Blood sugar testing done by the student with diabetes is a means of monitoring the blood sugar balance. When at school, blood sugar is usually tested before meals, before/during/after exercise and when feeling 'low'.
Blood sugar levels will change with eating (before and after), physical activity, stress, or illness. Sometimes the blood sugar fluctuates for no apparent reason.
Good management means avoiding very high or very low sugar levels and keeping as close to 'targets' as possible. Student 'targets', determined by doctor, are usually written in their diabetes diary or log book.
Knowing blood sugar levels will:

- Help the student understand the balance of food, medication, insulin and exercise
- Help the doctor adjust medication, insulin and food
- Help avoid the consequences of hypoglycemia and hyperglycemia
- Give early warning without waiting for onset of symptoms

Equipment: A small meter, which runs on batteries (there are various meters on the market), test strips, lancet device, lancets, log book.

Procedure for Blood Glucose Monitoring

- The student washes hands with warm water and soap
- Inserts a lancet in the lancet device
- Pokes the side of the fingertip with lancet and obtains a drop of blood. (Some models of meters allow the student to use their forearm for testing, rather than fingertips).
- Place a small drop of blood onto the test strip that is inserted into a blood sugar meter, also called a glucometer.
- Waits for 5 to 45 seconds, depending upon the meter, to read the results.
- Records the reading of the blood sugar in logbook or automatically recorded in meter.

Responsibility of School Staff

- To provide a safe and appropriate location.
- Where requested on the Student Diabetes Plan of Care to read the meter (e.g. reading is below 4.0) and provide the fast-acting sugar.
- Arrange for the safe disposal of lancets, test strips etc. (e.g. a container for sharps is provided by the school)

- Where appropriate, for the clean-up, follow school policy regarding universal blood and body fluids precautions.
- To ensure a young student (FDK to grade one) or newly diagnosed student will have a trained supervisor who knows their signs and symptoms of low blood sugar and provide appropriate intervention (e.g. when classroom teacher is unavailable or when an occasional teacher is in the room), consider having two or more staff who can also provide supervision when the classroom teacher is unavailable (e.g. noon hour supervisor, first aid provider, educational assistant, school administration.)

Fast Acting Sugar Readily Available at School Site and for all Off-Site Activities
Fast acting sugar is to be taken by the student to prevent or treat low blood sugar e.g. 175mls (6oz) juice; or 5-6 LifeSavers; or 3 glucose tablets.

Students must be permitted to take fast-acting sugar anywhere, and at any time on school property, on buses, or during school sanctioned activities.
The fast-acting sugar supplies are to be provided by the parents.

Responsibility of School Staff
- Provide safe and appropriate location(s) for storage of fast acting sugar.
- To notify parents when supplies of fast-acting sugar are becoming depleted.
- To carry additional supplies when activities take place off school site.
- Support the child in being able to take fast acting sugar anywhere and anytime.

Ketone Self-Monitoring
Ketones are substances that can be detected in the blood by students with diabetes using a blood ketone testing meter. In hyperglycemia, glucose stays in the blood and the body cannot use it for fuel. The body then breaks down fat for fuel. This process produces ketones as a by-product. Rising ketone levels can spiral into the potentially dangerous condition known as Diabetic Ketoacidosis (DKA). If left untreated DKA can have serious life-threatening results.

Causes: Too little insulin for the body's needs. Build-up of ketones can be caused by:
- Illness e.g. flu and stomach viruses
- Hyperglycemia over 14.0 mmol/l
- Frequent vomiting
- Over a period of days when blood sugar levels aren't managed

Symptoms of ketoacidosis:
Excessive thirst, nausea and vomiting, weight loss, leg cramps, breath smells fruity, abdominal pain, blurry vision.

Treatment:
Students with diabetes monitor their ketone levels according to guidelines prescribed by their healthcare professional using a blood ketone testing meter.

Responsibility of School Staff
- School staff have no responsibility in the student's testing procedures of ketone levels.
- Be supportive.
- Provide safe and appropriate location.

Insulin Injections
Students with Type 1 diabetes (and some Type 2 diabetes) lose the ability to internally regulate their blood sugar levels because the pancreas no longer makes sufficient insulin. The student must try to control their blood sugar levels using injected insulin.
The student may have to take an injection of insulin at lunchtime.

Insulin injections vary with the individual. Most injections are administered outside the school hours (before breakfast, and supper and at bedtime). The student and family are responsible for administering the insulin injection at school.

Recent advances in medical devices allow people with diabetes to choose the way the minister their insulin:

INSULIN SYRINGE

- Insulin syringe are specially made syringes for self-injection of insulin.

INSULIN PEN

- Insulin pens look like a pen and allow the student to dial in the desired dose.

INSULIN PUMP

- The student who wears an insulin pump receives insulin continuously via a small catheter placed under the skin (stomach).
- The student must press buttons on the pump to receive the correct dosage of insulin.
- The pump must be worn 24 hours a day and can only be taken off for short periods of time such as for physical education class.

Responsibility of School Staff

- To provide a safe and appropriate location.
- **School Staff do NOT provide** insulin syringe injections or push the button on the insulin pump (bolus).
- If the student's insulin pump beeps, allow them to contact parents to problem solve issues related to the pump.

Protocol when student is having difficulty with their diabetes or parent request for school to perform a management protocol:
Principal should contact the Local Health Integration Network (LHIN) and outline the situation and/or parents' request. A diabetes educator visits the school, assesses the situation and makes recommendations based on what the school staff can and cannot do and what role the parents and LHIN have in the situation (e.g. the student may need more instruction on the device).

Elementary Students – Helping the young student with diabetes succeed:

- Clear and regular communication between the parents and the school.
- Parents should be notified each time their child has a low blood sugar.
- Understanding that the young student (FKK, grade 1 & 2) may be unable to recognize the symptoms of low blood sugar and/or effectively communicate why they are feeling unwell. Being attentive to subtle changes in mood and behaviour can help a teacher identify when a student is experiencing a low blood sugar.

High and low blood sugars can make it difficult for the student to concentrate during class time, including tests and exams.

School Support:

- If a student misses classroom time, or if his/her cognition is impacted by lows and highs, give extra time to make up missed work, and other assignments.
- Accommodations for examinations, tests and quizzes. Students with diabetes are to be allowed to keep a diabetes emergency kit at their desk, including a glucose meter, hypoglycemia treatment, and snacks as required. In the event of a hypoglycaemic event in the half hour proceeding or at any time during an exam, a student is to be granted an additional 30-60 minutes as needed to allow for cognitive recovery from hypoglycemia.
- Encouragement and support from teachers can provide an important safety net for students who tried to adjust to all their new responsibilities.

Elementary Schools - Special Concerns for the Young Student

Checking Blood Sugars
The age at which a child is able to perform self-care tasks, such as checking their blood sugar is very individual and variable. The ability to use a meter develops much more quickly than the capacity to interpret the results. By age 8, most children can independently perform their own blood sugar checks.

Lunch/Nutrition Breaks:
- Allow students to eat when they need to.
- Encourage Student to eat all the food as outlined in their prescribed diet and/or as prepared by their parents.
- Teacher providing sufficient time for the child to eat all of the food is important because eating inadequately, delaying a meal or skipping a snack and easily cause low blood sugar.
- When appropriate classroom teacher to communicate with parent when there will be changes to the daily routine (e.g. if snack or activity times will be changed, extra activity, or an extended day (e.g. extra help, detention, sport activities)) so parents can ensure the child has additional snacks or make an insulin change to reduce the chance of a low blood sugar.

Supervision of students with diabetes during lunch/snack time:
When supervising multiple classrooms where there is/are student(s) with type 1 or type 2 diabetes the following strategies are to be in place:
- School has a process in place to identify the student in the classroom to the supervisor (teacher, noon hour supervisor, occasional teacher), and/or all lunch supervisors are instructed that prior to supervision duties to check each room for students with type 1 or type 2 diabetes.
- School administrator is to check that the supervisor (staff members, occasional teacher, paid lunch room supervisors) have been trained in recognizing the symptoms of a low blood sugar and knows the procedures and managing a low blood sugar reaction and/or emergency response procedures.
- Classes may use student monitors who can assist the supervising teacher.
- Students are to be in-serviced on their role as monitors and provided with direction to access the supervising adult immediately when the need arises.
- The identified student with diabetes, where appropriate, may be assigned an eating 'buddy' to access the supervisor immediately in case of an incident.
- Where age-appropriate, students in the class may be taught how to contact the office using classroom communication system in case of an emergency.
- Supervising adult informs students of his/her location of supervision (e.g. identifies the classroom he/she will be supervising).
- The following has been reviewed with the student with diabetes ahead of time:
    - To have their monitoring kit with them, at all times.
    - Recognize signs of low blood sugar.
    - Inform supervising staff member when they feel unwell/experiencing low blood sugar.
    - To eat all the food as outlined in their prescribed diet and/or as prepared by their parents.

Extenuating circumstances, (e.g. newly diagnosed student) may require further accommodations with supervision.

Activity:
Exercise can lower blood sugar levels.
- Playground supervisor should know which student has diabetes, what the signs and symptoms of a low blood sugar are and the action plan to manage the low blood sugar immediately.

Secondary Schools - Student Support
Students with type 1 or type 2 diabetes and must not only deal with the social and academic changes of high school but the physical changes that occur as well. They must also learn to take on a more independent role in the management of their diabetes.

There may be times when a teen, with diabetes, struggles with both the idea of having diabetes and carrying out the daily task for taking insulin, checking blood sugars, and monitoring food and exercise. There is no let-up in this rigorous program nor is there a vacation; therefore, it can happen that teens get tired and frustrated with it.

The teen may struggle with feeling different from their peers and may be reluctant to inform their teacher that they have diabetes. They may not wish to draw attention to their condition by wearing a medical information bracelet. They may also be embarrassed to check their blood sugar or take their insulin injection at school or around their friends. Caring for their diabetes may become less of a priority for them.

Supporting Secondary Students
High and low blood sugars can make it difficult for the student to concentrate during class time, including during tests and exams.

- If a student misses classroom time or an exam, or if his/her cognition is impacted by lows and highs, give extra time to make up missed work, tests, and other assignments.
- Accommodations for examinations, tests and quizzes. Students with diabetes are allowed to keep a diabetes emergency kit at their desk, including a glucose meter, hypoglycemia treatment, and snacks as required. In the event of a hypoglycaemic event in the half hour proceeding or at any time during an exam, a student is to be granted an additional 30-60 minutes as needed to allow for cognitive recovery from hypoglycemia.
- During exams allow the student to eat, drink and check their blood sugar level so that they can manage they diabetes accordingly.
- Allowing student to use the bathroom without drawing attention to them can be helpful.
- Avoid labelling the teen as diabetic, they have diabetes. It is a part of who they are, but it does not define them.
- Encourage the student to advocate for themselves.
- Encouragement and support from teachers can provide an important safety net for students who try to adjust to all their new responsibilities.

Treatment for Low Blood Sugar – Hypoglycemia

When in doubt, TREAT!

Causes	**Symptoms**	**Treatment**
Low blood glucose usually develops as a result of one or more of the following: • Insufficient food due to delayed or missed meal • More exercise or activity than usual without a corresponding increase in food; and/or too much insulin	The student may say he/she feels “low”, may look unwell or act in a. Strange manner. **Signs of a low blood sugar include:** Cold, clammy, sweaty skin, paleness, quietness, fatigue, dizziness, shakiness, hunger, irritability, tearfulness ~~~~~~~~~~~~~~~~~~~~ **Signs of a VERY low blood sugar include:** Loss of coordination, hostility, confusion, staggering gait. Appearing intoxicated	At the first sign of a low blood sugar allow the student to check their blood sugar level using their meter. If the reading is **below 4.0** (or otherwise directed by parent) ensure the student **takes** their **fast-acting sugar** immediately. **If it is not possible to check blood sugar OR if in doubt TREAT!** **(give sugar immediately)** ~~~~~~~~~~~~~~~~~~~~ If the parents have not provided you with more specific instructions which can be readily complied with, give: • 175 mld (6oz) juice or pop (not diet); or • 5-6 lifesavers; or • 3 glucose tablets or as directed by parent • 2 tsp/10 ml/ or 2 packets of sugar; or

	~~ **Signs of a SEVERE low blood sugar include:** Unconscious, unresponsive, cannot swallow properly seizure	• 2 tsp/10ml of honey Follow up as per Diabetes Plan ~~~~~~~~~~~~~~~~~~~~ • NEVER give food or drink • Place student on their side. • Call 911 • Inform EMS student has Type 1 or Type 2 Diabetes • Call emergency contact

- If unsure whether the child is hypoglycaemic, **always give sugar**! A temporary excess of sugar will not harm the child, but hypoglycemia is potentially serious.
- The student whose blood sugar is low, may not be able to think clearly, and NEEDS to be supervised, by an adult, until they feel better.
    - Never leave the student alone
    - Do not send to the office
    - Do not allow student to use stairs
- It may take some coaxing to get the child to eat or drink, but you must insist.
- If there is no noticeable improvement in about 10 to 15 minutes **repeat the treatment**. When the child's condition improves, he or she should be given solid food. This will usually be in the form of the child's next regular meal or snack.
- Until the child is fully recovered he/she should not be left unsupervised. Once the recovery is complete the child can resume regular class work. If, however, it is decided that the child should be sent home, it is imperative that a responsible person accompany him or her.

When to Call Parent

- A low blood sugar that requires assistance (e.g. if it takes longer than 15 minutes to recover from low blood sugar).
- If there are frequent low blood sugars in a week.
- Illness. If the student is VOMITING phone parents immediately. If you were unable to reach them, call 911.
- If insulin pump is beeping. Allow student to call parents to solve problem.

Severe Low Blood Sugar – Hypoglycaema – Glucagon Injection:
When the blood sugar level get so low that the student is unable to take his/her fast acting sugar orally because they are unresponsive, unconscious or having a seizure the treatment is for an injection of glucagon. Glucagon is a hormone made in the pancreas that quickly rises blood sugar. Glucagon is given as an injection like insulin by parents or trained EMS paramedics.
School Staff do NOT Administer Glucagon Injections.

Emergency response of school staff is to call 911 immediately and inform the emergency services that the student has diabetes.

Emergency medical services personnel require the following, if available:

- Student's name, date of birth, emergency contact information
- Medical history - available on the students Plan of Care form
- Observations about what the student was doing prior to the event
- Medications and any treatment prior to EMS arrival

Treatment for Hyperglycemia – High Blood Sugar
Children with diabetes sometimes experience high blood sugar. Hyperglycemia is NOT an emergency situation, unless student is vomiting, and it may require accommodations in the classroom.

High Blood Glucose Causes
May develop as a result of one or more of the following:

- Too much food;
- Less than the usual amount of activity (indoor recess);
- Growth spurts
- Stress
- Not enough insulin; and/or
- Illness

Symptoms
The earliest and most obvious symptoms are **increased thirst and urination.**
Other: dry mouth, blurred vision, drowsiness.

Treatment:
Allow the student to check their blood sugar since symptoms of high blood sugar can be confused with symptoms of low blood sugar. Blood sugar levels >14 are usually considered too high, but refer to student's Plan of Care for individual parameters.

- Allow the student to drink water at their desk
- Allow the student to have open bathroom privileges
- Do not use exercise to lower blood sugars as this can potentially make the blood sugar go higher.

EMERGENCY if student is VOMITING:

- Phone parents immediately
- If parents are not available CALL 911
- Inform EMS student has Type 1 or Type 2 Diabetes

In the classroom, the behaviour students with hyperglycemia maybe taking for misbehaviour (i.e. frequent request to go to the bathroom or request for frequent drinks).

Field Trips and Students with Diabetes (Day Trips, Overnight Trips, Expensive Trips, Exchange Programs)

- **Process in place to identify students with diabetes type 1 and/or type 2**
- **Trip site and activities are to be checked for potential safety hazard.** Where possible, a pre-activity inspection of the site in activities by the trip supervisor to investigate safety conditions should be carried out.
- **Communicate with the child's parents/guardians** during the initial planning stages of the trip informing them of the destination, mode of travel and activities students are to participate in. This will allow for parent/guardian input in the school developing a clear set of expectations and accommodations to meet their child's medical needs on the trip. Knowing the trip expectations and accommodations the parents will be able to provide an informed decision as to their child's participation. You may consider inviting parent on the trip as a supervisor.
- For day, overnight, extensive or exchange programs parents are to be consult it on:
    - Medication
    - Insulin, glucagon - amount, when taken, how it is administered, dosage.
    - Blood testing kit and contents of fast acting sugar
      Note: inform parent/guardian that during the trip that **School Staff do NOT**:
        - Administer insulin syringe injections
        - Administer glucagon syringe injections
        - Push the release button on the insulin pump (e.g. manually provide a bolus dose (a burst of insulin) prior to the student eating).
- **Tour operator and/or activity provider**:
    - In charge teacher is to identify the students with type 1 and/or type 2 diabetes
    - Request operators to provide you with their accommodations for students with diabetes.

- Compare tour operator's accommodations plans with school board's expectations for accommodations for one of its students.
- Adjust operator's accommodation plan accordingly to the needs of the student. Follow the plans whereever there is a higher standard.
- If the trip provider does not have a pre-existing plan for the student's medical condition:
    - Develop one on your own based on school board expectations and parent input and
    - Provide the operator with a copy
- Based on list of accommodations for the student the tour operator must provide:
    - Safe accommodations during travel to destination
    - Safe facilities, safe programming, safe foods at the destination
    - Ready access to a doctor, clinic or hospital at destination site

- **An emergency action plan for student with Type 1 and/or Type 2 diabetes** must be prepared by the in-charge teacher and communicated to all staff and volunteers on the trip.
- **Student forms on the trip –** copy of the student's Diabetes Plan of Care along with trip accommodations, where appropriate, are to be taken on the trip.
- **Grouping of student(s)**: student is to assigned to a group with staff member who is knowledgeable about managing low blood sugar and/or high blood sugar situations.
- **Buddy system:** In situations where the teacher/supervisor is providing 'in the area supervision' the teacher is to assign a buddy to the student. The 'buddy's' responsibility is to assist the student and to access the teacher supervisors in case of an emergency.
- **A suitable means of communication** (e.g. cell phone) to be taken on the trip and/or an easily accessible phone is available at the site. Ensure that you have the correct and proper change if using payphones.
- **Trip supervisors to meet students** ahead of time who have diabetes and provide the following information:
    - Recognize your symptoms of a low blood sugar and/or high blood sugar and how to take age appropriate action to treat the symptoms.
    - Eat all and only what parents/guardians have approved.
    - Take responsibility for bringing and looking after your blood glucose monitoring and insulin injection apparatus.
    - Know (in age appropriate ways) how to administer the blood sugar monitoring system, blood testing, insulin injection, safe disposal of lancets and needles, how to manage and use appropriately the insulin pump (e.g. administering a bolus dose).
    - Promptly inform an adult that you have diabetes as soon as symptoms appear or when experiencing a general feeling of 'un-wellness'.
    - Never isolate yourself when checking blood sugar, administering your insulin or feeling unwell.

ROLE of Parents/Guardians with School:
In order for School Staff to provide a safe and nuturing environment for students managing their diabetes are asked to:

- **<u>Provide Proof of Diagnosis for student which can be ONE of</u>**:
    - A letter/note from the physician or specialist, OR
    - A copy/photocopy of the prescription, OR
    - A photocoy of the prescription from the medicine container, OR
    - A copy/photcopy of the Offical Receipt of the medication from the pharmacist
- **<u>COMPLETE and return the following forms found in this package</u>:**
    - **STUDENT PLAN OF CARE**
        - Parents/Guardians of newly registered or newly diagnosed students shall create the Student Plan of Care in consultation with School Adminstration during the last week of August or as soon as possible to starting the school year. For students already registered, **the Student Plan of Care should be reviewed and/or**

updated annually and shared with the school, before the start of each school year.

- **CONSENT FORM TO CARRY AND ADMINISTER MEDICATION/DISCLOSE PERSONAL INFORMATION**
  - Form is completed by Parent/Guardian to carry and self-administer medication. Also includes consent to share life-threatening condition with pertinent individuals.

Please Note – Urgency of Having Completed Forms as Soon as Possible:
To act in the best interest of student responding to a reaction, parents/guardians are strongly encouraged to provide all relevant information and forms to manage student's diabetes to the school principal in a timely manner. Failure to do so may place student at unnecessary risk.

- **COMMUNICATE with School Administrator that student requires professional health services within the school setting to assist with management protocols:**

Procedures

- Arrange with the principal to discuss.
- Complete an application form to the LHIN (Local Health Integration Network)
- A LHIN case manager will contact parent and principal and complete an asessment of the student's health care needs in the school setting.
- A multidisciplinary conference may be required to identify the needs at school and to determine eligibility for services.
- On admission, goals will be determined and a service plan developed to ensure the safest possible learning environment for student.
- On occasion, there may be a waiting period for some services, and/or a lack of availability of service providers. In these circumstances, the LHIN will work with parents and school staff to develop a safe plan for the student.

- **UPDATE Changes of information: Emergency Contact, Medication, Medical Diagnosis**:

Parents are responsible to inform School administration of any changes to contact information, medication or medical condition diagnosis as soon as reasonable possible. Forms can be accessed through the school office.
NOTE: Changes to student's diagnosis must be accompanied by a note/letter from student's physician indicating the change.
Please Note: Board employees are not trained health professionals

Prevention

- **COMMUNICATE, when student is transitioning to a new school**

Parents/Guardians should ask for a most recent copy of student's Diabetes Student Plan of Care. Parents/Guardians are requested to update the form with recent medical and contact information and to provide the completed form to the receiving school administrator/designate during a transition meeting.
PROVIDE a constant supply of fast acting sugar, to prevent and treat low blood sugar.

- **PROVIDE, when appropriate, an extra snack** (e.g. trips)
- **PROVIDE a clearly labelled (student name, address) container** which includes blood glucose monitoring items and insulin items and medication.
- **CONSIDER providing a MedicAlert bracelet or necklace for your child,** and discuss the importance of wearing it. The form can be obtained by calling 1-800-668-1507 or visit www.medicalert.ca

Responsibilities of Parent/Guardian with their Child:
Communicate the following information and responsibilities to the child in managing their diabetes. Review with child when appropriate.

- Provide age appropriate understanding of their diabetes, how to recognize the symptoms of a low blood sugar and high blood sugar and how to take age appropriate action to treat their symptoms.
- Provide age appropriate information on how to administer the blood sugar monitoring system, blood testing, insulin injection, safe disposal of lancets and needles, how to manage and use appropriately the insulin pump (e.g. administering a bolus dose).

- The importance of carrying/having immediate access to their blood sugar testing kit, fast acting sugar and insulin injection apparatus at all times.
- Guide and encourage child to self-management and self-advocacy.
- Inform child that when they are having an attack, never remove themselves to a secluded area or go off to be by themselves (e.g. washroom) and to tell a teacher, staff member or a classmate when feeling a reaction or when feeling unwell.
- The importance of eating all and only what parents/guardians have a provided.
- Inform, check and review when necessary with child the location of their blood sugar testing kit, insulin injection apparatus and fast acting sugar during the school day and at school sponsored activities.
- Remind the child, prior to the child leaving for school, to check that the container for carrying (e.g. 'fanny pack', purse) contains the blood sugar testing kit, insulin apparatus and fast acting sugar.
- Talk to their friends about their diabetes and let them know how they can help them.
- Communicate with parents/school staff if they are facing challenges related to their diabetes, including any and all teasing, bullying, threats or any other concerns they have.
- Consider providing Medical Alert identification for your child (e.g. bracelet or necklace). The form can be obtained by calling 1-800-668-1507 or visit www.medicalalert.ca

Responsibilities of Students (where appropriate)

- Advocate for their personal safety and well-being
- Participate in the development and review of Plan of Care
- Carry out daily or routine self-management of their medical conditions as described in their Plan of Care
- Set goals on an ongoing basis for self-management of their medical condition in conjunction with their parents and healthcare professional
- Recognize their symptoms of a low blood sugar and high blood sugar and how to take age appropriate action to treat the symptoms.
- Eat all only what parents/guardians have approved.
- Check prior to leaving home that they have their blood sugar testing kit, insulin apparatus and fast acting sugar.
- Take responsibility for carrying their blood sugar testing kit and insulin injection apparatus and fast acting sugar during the school day and at school sponsored activities.
- Check that blood sugar testing kit, insulin injecting apparatus and fast acting sugar is always accessible to their location.
- Know, in age appropriate ways, how to administer the blood sugar monitoring system, blood testing, insulin injection and safe disposal of lancets and needles, how to manage and use appropriately the insulin pump.
- Promptly inform an adult that they have diabetes as soon as symptoms appear or when experiencing a general feeling of 'un-wellness'.
- Never isolate themselves when checking blood sugar or feeling unwell.
- Communicate with parents/school staff that they are facing challenges related to their diabetes, including any, and all, teasing, bullying, threats or any other concerns they have.
- Wear/carry medical alert and identification when parent/guardian deems appropriate.

SCHOOL FORMS

- **STUDENT PLAN OF CARE: DIABETES**
    - To identify child to others, this form will be created by family and the school team. The School Administrator will share with appropriate school staff and post as necessary.
    - The Transportation Consortium's Medical Information Form must also be filled in by a medical professional http://www.businfo.ca/en/pdf/forms/F-M04-404%20-%20Medical%20Note.pdf
- **AT-A-GLANCE MEDICAL CONDITION IDENTIFICATION**

To identify child to others, an At-A-Glance document is created, by the School Administrator/Designate, which includes the student's name, grade, picture, and medical condition only and is only posted in pertinent staff areas (i.e. staff room).

- **CONSENT FORM TO CARRY AND ADMINISTER MEDICATION/DISCLOSE PERSONAL INFORMATION**
    - Form is completed by Parent/Guardian to carry and self-administer medication. Also includes consent to share life-threatening condition with pertinent individuals.

PREVALENT MEDICAL CONDITION — DIABETES
Plan of Care

STUDENT INFORMATION

Student Name _____ Date of Birth _____

Ontario Ed. # _____ Age _____

Grade _____ Teacher(s)_____

Student Photo

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

DIABETES SUPPORTS

Names of trained individuals who will provide support with diabetes-related tasks: (e.g. designated staff or community care allies.) _____

_____

Method of home-school communication: _____

Any other medical condition or allergy? _____

_____

DAILY/ROUTINE DIABETES MANAGEMENT	
Student is able to manage their diabetes care independently and does not require any special care from the school. ❒ Yes ❒ No ❒ If Yes, go directly to page five (5) — Emergency Procedures	
ROUTINE	**ACTION**
BLOOD GLUCOSE MONITORING ❒ Student requires trained individual to check BG/ read meter. ❒ Student needs supervision to check BG/ read meter. ❒ Student can independently check BG/ read meter. ❒ Student has continuous glucose monitor (CGM) ✸ Students should be able to check blood glucose anytime, anyplace, respecting their preference for privacy.	Target Blood Glucose Range _____ Time(s) to check BG: _____ _____ Contact Parent(s)/Guardian(s) if BG is: _____ Parent(s)/Guardian(s) Responsibilities: _____ _____ School Responsibilities: _____ _____ Student Responsibilities: _____
NUTRITION BREAKS ❒ Student requires supervision during meal times to ensure completion. ❒ Student can independently manage his/her food intake. ✸ Reasonable accommodation must be made to allow student to eat all of the provided meals and snacks on time. Students should not trade or share food/snacks with other students.	Recommended time(s) for meals/snacks: _____ Parent(s)/Guardian(s) Responsibilities: _____ _____ School Responsibilities: _____ _____ Student Responsibilities: _____ Special instructions for meal days/ special events: _____ _____

ROUTINE	ACTION (CONTINUED)
INSULIN ❒ Student does not take insulin at school. ❒ Student takes insulin at school by: ❒ Injection ❒ Pump ❒ Insulin is given by: ❒ Student ❒ Student with supervision ❒ Parent(s)/Guardian(s) ❒ Trained Individual ✸ All students with Type 1 diabetes use insulin. Some students will require insulin during the school day, typically before meal/nutrition breaks.	Location of insulin: _____ _____ Required times for insulin: _____ ❒ Before school: ❒ Morning Break: ❒ Lunch Break: ❒ Afternoon Break: ❒ Other (Specify): _____ Parent(s)/Guardian(s) responsibilities: _____ School Responsibilities: _____ Student Responsibilities: _____ Additional Comments: _____
ACTIVITY PLAN Physical activity lowers blood glucose. BG is often checked before activity. Carbohydrates may need to be eaten before/after physical activity. A source of fast-acting sugar must always be within student's reach.	Please indicate what this student must do prior to physical activity to help prevent low blood sugar: 1. Before activity: _____ 2. During activity: _____ 3. After activity: _____ Parent(s)/Guardian(s) Responsibilities: _____ School Responsibilities: _____ Student Responsibilities: _____ For special events, notify parent(s)/guardian(s) in advance so that appropriate adjustments or arrangements can be made. (e.g. extracurricular, Terry Fox Run)

ROUTINE	ACTION (CONTINUED)
DIABETES MANAGEMENT KIT Parents must provide, maintain, and refresh supplies. School must ensure this kit is accessible all times. (e.g. field trips, fire drills, lockdowns) and advise parents when supplies are low.	Kits will be available in different locations but will include: ❒ Blood Glucose meter, BG test strips, and lancets ❒ Insulin and insulin pen and supplies. ❒ Source of fast-acting sugar (e.g. juice, candy, glucose tabs.) ❒ Carbohydrate containing snacks ❒ Other (Please list) _____ _____ Location of Kit: _____
SPECIAL NEEDS A student with special considerations may require more assistance than outlined in this plan.	Comments:

EMERGENCY PROCEDURES

HYPOGLYCEMIA – LOW BLOOD GLUCOSE
(4 mmol/L or less)

DO NOT LEAVE STUDENT UNATTENDED

Usual symptoms of Hypoglycemia for my child are:

❒ Shaky	❒ Irritable/Grouchy	❒ Dizzy	❒ Trembling
❒ Blurred Vision	❒ Headache	❒ Hungry	❒ Weak/Fatigue
❒ Pale	❒ Confused	❒ Other _____	

Steps to take for Mild Hypoglycemia (student is responsive)

1. Check blood glucose, give _____grams of fast acting carbohydrate (e.g. ½ cup of juice, 15 skittles)
2. Re-check blood glucose in 15 minutes.
3. If still below 4 mmol/L, repeat steps 1 and 2 until BG is above 4 mmol/L. Give a starchy snack if next meal/snack is more than one (1) hour away.

Steps for Severe Hypoglycemia (student is unresponsive)

1. Place the student on their side in the recovery position.
2. Call 9-1-1. Do not give food or drink (choking hazard). Supervise student until emergency medical personnel arrives.
3. Contact parent(s)/guardian(s) or emergency contact

HYPERGLYCEMIA — HIGH BLOOD GLOCOSE
(14 MMOL/L OR ABOVE)

Usual symptoms of hyperglycemia for my child are:

❒ Extreme Thirst	❒ Frequent Urination	❒ Headache
❒ Hungry	❒ Abdominal Pain	❒ Blurred Vision
❒ Warm, Flushed Skin	❒ Irritability	❒ Other: _____

Steps to take for Mild Hyperglycemia

1. Allow student free use of bathroom
2. Encourage student to drink water only
3. Inform the parent/guardian if BG is above _____

Symptoms of Severe Hyperglycemia (Notify parent(s)/guardian(s) immediately)

❒ Rapid, Shallow Breathing	❒ Vomiting	❒ Fruity Breath

Steps to take for Severe Hyperglycemia

1. If possible, confirm hyperglycemia by testing blood glucose
2. Call parent(s)/guardian(s) or emergency contact

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____

Special Instructions/Notes/Prescription Labels:

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.
✸This information may remain on file if there are no changes to the student's medical condition.

PLAN

This plan remains in effect for the 20___— 20___ school year without change and will be reviewed on or before: _____. (It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year).

Parent(s)/Guardian(s): _____ Date: _____
Signature

Student: _____ Date: _____
Signature

Principal: _____ Date: _____
Signature

PLAN REVIEW

Where there is no change in the child's condition or treatment strategy from the previous year(s), parents may authorize continuation of the protocol with initials below.

☐ There has been no change in condition or treatment strategy from previous year. Parent initial: _____

Date: _____

☐ There has been no change in condition or treatment strategy from previous year. Parent initial: _____

Date: _____

☐ There has been no change in condition or treatment strategy from previous year. Parent initial: _____

Date: _____

CONSENT FORM
TO CARRY AND ADMINISTER MEDICATION/DISCLOSE PERSONAL INFORMATION

TO BE SIGNED BY PARENT/GUARDIAN UNLESS THE STUDENT IS 18 YEARS OF AGE OR OLDER

ADMINISTRATION OF MEDICATION

In the event of my child _____ experiencing a medical emergency, I consent to the administration of _Fast Acting Sugar (specify type of medication) by an employee of the Sudbury Catholic District School Board as prescribed by the physician and outlined in the Emergency Procedures of the Prevalent Medical Conditions Policy/Administrative Procedure.

PLEASE PRINT Student's Name: _____ Name of Parent/Guardian: _____ Signature of Parent/Guardian: _____ Signature of Student (if 18 or older): _____	Class/Teachers' Names: Date: _____ Date: _____

MAINTENANCE OF MEDICATION

I understand that it is the responsibility of my child _____to carry _____ (specify type of medication) on his/her person.

PLEASE PRINT Student's Name: _____ Name of Parent/Guardian: _____ Signature of Parent/Guardian: _____ Signature of Student (if 18 or older): _____ Name of Physician: _____	Class/Teachers' Names: Date: _____ Date: _____ Contact # _____

COLLECTION, DISCLOSURE AND USE OF PERSONAL INFORMATION

Authorization for the collection and maintenance of the personal information recorded on the Prevalent Medical Conditions form is the Municipal Freedom of Information and the Protection of Privacy Act. Users of this information should be directed by the principal of the school.

OPTIONAL:
Additionally, I further consent to the disclosure and use of the personal information collected herein to persons, including persons who are not the employees of the Sudbury Catholic District School Board through the posting of photographs and medical information of my child (Plan of Care/Emergency Procedures) in the following key locations:

☐ Classroom	☐ Staffroom	☐ Lunchroom
☐ Office	☐ Gym	☐ Learning Commons/Library
☐ Other: _____	☐ Other: _____	

and through the provision of personal information contained herein to the following persons who are not employees of the Board: please check (✓) all applicable boxes

☐ Food Service Providers	☐ Child Care Providers
☐ School Volunteers in regular direct contact with child	☐ Other: _____

Signature of Parent/Guardian: _____	Date: _____
Signature of Student (if 18 or older): _____	Date: _____
Signature of Principal: _____	Date: _____

We release the Sudbury Catholic District School Board, its employees and agents from any and all liability for loss, damage or injury, howsoever caused to my/our child's person, or property, or to me/us as a consequence, arising from administering the interventions, failing to correctly administer the interventions and/or failing to administer any intervention listed in Diabetes Student Plan of Care.

Signature of Parent/Guardian: _____	Date: _____
Signature of Student (if 18 or older): _____	Date: _____

PLEASE NOTE THIS CONSENT EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR

This information is collected pursuant to s. 170 and s.265(1)i) of the Education Act, R.S.O. 1990, c. E-2 and s.28(2), 29, 30, 31,32 and 33 of the Municipal Freedom of Information and Protection of Privacy act, R.S.O. 1990, c. M-56: and the Personal Health Information Protection Act, 2004, S.O. 2004, c.3, Sch. A.
If you have any questions regarding your child's personal information, please contact the Principal of your child's school.

AT-A-GLANCE Medical Condition IDENTIFICATION

Student Name	Grade	Medical Condition	Picture (If avaialble)

MEDICAL INCIDENT RECORD FORM						
Student Name	Time of Incident	Length of Incident	Events before Incident	Description of Incident	Events after Incident	Date/Time Parent/Gaurdian Contacted

Appendix D: Epilepsy

PREAMBLE

This Epilepsy and Seizure Disorder Protocol addresses the components of Ministry of Education Policy/Program Memorandum 161 Supporting Children and Students with Prevalent Medical Conditions (Anaphylaxis, Asthmas, Diabetes, and/or Epilepsy) in Schools.

Rationale for an Epilepsy and Seizure Disorder Management Protocol
The goal of this protocol is to educate school personnel about epilepsy and seizure disorders, its causes, symptoms and treatments so that a child diagnosed with a seizure disorder can have the support needed in the school setting or on a school trip to be safe and successfully participate in their education.

Purpose
The purpose of this APG is to promote the safety and well-being of all students. The SCDSB expects all schools within the Board support students in schools who have epilepsy and seizure disorder. These medical conditions, hereafter referred to as prevalent medical conditions, have the potential to result in a medical incident or life-threatening emergency.

Supporting students with prevalent medical conditions in schools is complex. A whole-school approach is needed where education and community partners, including health care professionals have important roles to play in promoting student health and safety and in fostering and maintaining healthy and safe environments in which students can learn.

In developing, revising, implementing, and maintaining their policies to support students with prevalent medical conditions, schools should take into account local needs and circumstances, such as geographical considerations, demographics, and cultural considerations, as well as the availability of supports and resources, including school staff, within the school board and community. School boards should consult with parents, students, principals' associations, teachers' federations, education workers' unions, school staff, volunteers working in their schools, their school councils, Joint Health and Safety Committees, community health care professionals, Parent Involvement Committees, and Special Education Advisory Committees.

GUIDELINES

What is Epilepsy/Seizure Disorder?
Epilepsy:
A disorder of the central nervous system, specifically the brain, characterized by spontaneous, repeated seizures. Epilepsy, also known as a seizure disorder, is not often talked about in public. Misconceptions and fears persist that are sometimes more burdensome to persons living with epilepsy than the seizures themselves. The fact is, epilepsy is not a disease but a common neurological disorder affecting one out of every hundred Canadians. Anyone can develop epilepsy at any time without a known cause. Most often diagnosed in children and in seniors, epilepsy affects each person differently. Many people with epilepsy successfully control their seizures with medication and are able to enjoy healthy and fulfilling lives.

Seizure:

A seizure occurs when the normal electrical balance in the brain is lost. The brain's nerve cells misfire: they fire either when they shouldn't, or they don't fire when they should. The result is a sudden, brief, uncontrolled burst of abnormal electrical activity of the brain. Seizures are the physical effects of such unusual bursts of electrical energy in the brain and may include muscle spasms, mental confusion, loss of consciousness, uncontrolled or aimless body movement, incontinence and vomiting.

Note:

- Seizures are not contagious
- Seizures are not the child's fault
- Many seizures are hidden
- Seizures are not dangerous to others

Conditions that may cause seizures:

- Epilepsy
- Medical conditions where seizures may be among the symptoms, such as:
    - Cerebral Palsy (25% to 35% of the population has seizure occurrence)
    - Intellectual disability (as much as 1/3 of the population can have seizure occurrence)
    - Angelman's syndrome
- Physical trauma/injuries to the head and/or brain

Types of Seizures

The type of seizure depends on where in the brain the discharge begins.

Some children have just one type of seizure, but it is not unusual for more than one type of seizure to occur in the same child. There are more than 40 types of seizures but most are classified into two main types of seizures. If the electrical discharge disturbs the whole brain, the seizure is called generalized. If the seizure disturbs only one part of the brain, it is called partial.

Status Epilepticus is a state of prolong seizure (longer than 30 minutes) or repeated seizures without time for recovery and can happen with any type of seizure. It is a medical emergency.

GENERALIZED SEIZURES

- **Absence Seizures**, formerly petite mal seizures, are brief periods of complete loss of awareness. The child may stare into space - completely unaware of surroundings and unable to respond. These seizures start and end abruptly, without warning. They only last a few seconds. The child may stop suddenly in midsentence, stare blankly, then continue talking without realizing that anything has happened. Rapid blinking, mouth or arm movement may occur.
  During absence seizures, the child is not day dreaming, forgetting to pay attention or deliberately ignoring your instructions. These seizures happen many times a day, interrupting attention and concentration. Absence seizures often disappear before adolescence.
- **Tonic-clonic Seizures,** formerly known as grand mal seizures, are general convulsions with two parts. First, in the tonic phase, the child may give a loud cry or grown. The child loses consciousness and falls as the body grows rigid. Second, in the clonic phase, the child's muscles jerk and twitch. Sometimes the whole body is involved; at other times, just the face and arms. Shallow breathing, flushed skin or lips, heavy drooling and loss of bladder or bowel control may occur. These seizures usually last 1 to 3 minutes. Afterwards, consciousness returns slowly and the child may feel groggy and want to sleep. The child will not remember the seizure.
- **Infantile Spasms** are rare. They occur in clusters in babies usually before six months of age. The baby may look startled or in pain, suddenly drawing up in the knees and raising both arms as if reaching for support. If sitting, the infant's head may suddenly slump forward, the arms flexed forward and the body flexes at the waist. Spasms last only a few seconds but often repeat in a series of 5 to 50 or more many times a day. They often occur when the baby is drowsy, on awakening or going to sleep.
- **Atypical Absence Seizures** involves pronounced jerking or automatic movements, a duration of longer than 20 seconds, and incomplete loss of awareness.
- **Myoclonic Seizures** involves a sudden, shocking jerk of the muscles in the arms, legs, neck and trunk. This usually involves both sides of the body at the same time and the student may fall over.

- **Atonic Seizures** last a few seconds. The neck, arms, legs or trunk muscles suddenly lose tone or loss of tone without warning. The head drops, the arms lose their grip, the legs lose strength or the person falls to the ground. Students with atonic seizures may have to wear a helmet to protect their head from injury during a fall. Child's surroundings may need to be altered to ensure safety.

PARTIAL SEIZURES

- **Simple Partial Seizures**, formerly known as focal seizures, cause strange and unusual sensations, distorting the way things look, sound, taste or smell. Consciousness is unaffected - the child stays awake but cannot control sudden, jerky movements or one part of the body.
- **Complex Partial Seizures,** formerly known as psychomotor or temporal lobe seizures, alter the child's awareness of what is going on during the seizure. The child is dazed and confused and seems to be in a dream or trance. The child is unable to respond to directions. The child may repeat simple actions over and over (e.g. head turning, mumbling, pulling at clothing, smacking lips, making random arm or leg movements or walk randomly). The seizure last only a minute or two but the child may feel confused or upset for some time and may feel tired or want to sleep after the seizure.

Myths: Common Misconceptions-Epilepsy Ontario

- *You can swallow your tongue during a seizure*. It is physically impossible to swallow your tongue.
- *You should force something into the mouth of someone having a seizure*. Absolutely not! That is a good way to chip teeth, puncture gums, or even break someone's jaw. The correct first aid is simple: gently roll the person onto their side and put something soft under their head to protect from injury.
- *You should restrain someone having a seizure*. Never use restraint! The seizure will run its course and you cannot stop it.

Causes of Seizures:

- For **60 to 75%** of all cases there is no known or idiopathic causes.
- **40%** are caused by abnormality in the brain that interfere with electrical workings. For example:
    - Brain injury (caused by tumor, stroke or trauma)
    - Birth trauma (e.g. lack of oxygen during labour)
    - Poisoning from substance abuse or environmental contaminants (e.g. lead)
    - Aftermath of infection (e.g. meningitis, encephalitis, measles)
    - Alteration in blood sugar (e.g. hypoglycaemia)
- in most cases, epilepsy is not inherited. Everyone inherits a "seizure threshold" - when brain cells are irritated beyond this point, we will have a seizure. People with a lower seizure threshold tend to develop seizures more easily than others.

POTENTIAL TRIGGERS OF EPILEPSY/SEIZURE DISORDER

- Stress - both excitement and emotional upset
- Lack of sleep
- Illness
- Poor diet
- Menstruation cycle
- Changes in weather
- Televisions, videos, flashing lights (including flickering overhead lights)
- Inactivity
- Improper medical balance

Duty of Care
This Epilepsy/Seizure Disorder Protocol for school administrators, teachers and other employees has been developed to meet the requirements of:
Education Act:
Education Act 265 (1): Duties of Principals
j) care of pupils and property – to give assiduous attention to the health and comfort of the pupils

Education Act, Regulations: Reg. 298, S20: Duties of Teachers
g) ensure that all reasonable safety procedures are carried out in courses and activities for which the teacher is responsible

Common Law Duties Owed by Teachers:
To assist or allow a student to seek medical attention as a careful parent would. The board's liability policy provides coverage for employees acting within the scope of their duties with the board. Best, all school staff who administer first aid to a student who is suffering from a seizure within the school or during a school activity, are covered.

Communication of Information on Epilepsy/Seizure Disorder
The Board public webpage offers resources that include information about epilepsy/seizure disorder that can be shared with all parents/guardians, students, employees, volunteers, coaches and other persons who have direct contact with a student with epilepsy/seizure disorder. School administrators are asked to consider including links in school newsletters, on the school website or and other pertinent areas.
This information is intended to assist people in understanding epilepsy/seizure disorders.
The school principal/designate shall work with staff and students to help ensure that an epilepsy/seizure disorder friendly school environment exists that is safe and supportive for all students.

Identification
Have a process in place so that children with an epilepsy/seizure disorder condition are identified to the school system by parents/guardians and requested to supply information on the epilepsy/seizure disorder condition.

- **Students, new to the school, during registration**
  Question during intake meeting specifically asking whether or not child has epilepsy/seizure disorder (or has any other medical conditions). Epilepsy/Seizure Disorder Student Plan of Care provided to parent/guardian for further information regarding epilepsy/seizure disorder triggers, etc.
- **Students presently registered at school**
  At the beginning of each school year, the school principal/designate shall have a process in place of requesting parent/guardian/adult student to identify if there is a new diagnosis of epilepsy/seizure disorder (throughout the school year)
- **Ensure student's medical condition(s) are entered** into the board's student database system.
- **Principals will ensure the creation/revision** of the Student Plan of Care and keep a copy of any prescriptions

Development of the Epilepsy/Seizure Disorder Student Plan of Care
The parent/guardian in consultation with the principal shall create, review and update the Plan of Care during September, or on the date as requested by the school administrator.
The plan shall be reviewed by the principal/designate in consultation with the parent/guardian/adult student following the Epilepsy/Seizure Disorder Protocol, on an annual basis or when there is a change in the child's condition or changes to the prescribed medication. Where appropriate the classroom teacher is to be part of the information sharing process.

The child's Epilepsy/Seizure Disorder triggers are to be identified and avoidance strategies are to be developed and implemented.

Instruction for Managing a Seizure

When to Call 911 – Emergency Medical Services:

- **Students not diagnosed with Epilepsy/Seizure Disorder:**
  - **CALL 911 IMMEDIATELY**
- **Generalized Convulsive Seizure (e.g. Tonic Clonic Seizure):**
  - **CALL 911 IMMEDIATELY**

Unless: you are aware of a different protocol for this student as outlined in the Student's Epilepsy and Seizure Disorder Student Plan of Care
IF IN DOUBT – CALL 911

Steps in Managing an individual Experiencing a Seizure:
Generalized Convulsive Seizures – Response:

1. **Keep calm. Stay with the person**
   - Take note of the time when seizure begins and length of seizure (e.g. stopwatch).
2. **Do not restrain or interfere with the person's movements**
   - Do not try to stop the seizure, let the seizure take its course
3. **Protect from further injury where possible**
   - Move hard or sharp objects away
   - Place something soft under the head (e.g. pillow, article of clothing)
   - Loosen tight clothing especially at the neck
4. Do not place or force anything in the person's mouth
   - Doing so may cause harm to the teeth, gums or even break someone's jaw
   - It is physically impossible to swallow the tongue
   - The person may bite their tongue and/or inside of their mouth
5. Roll the person to their side after the seizure subsides:
   - Sometimes during and after a seizure a person may vomit or drool a lot. To prevent choking, simply roll the person on their side. That way, fluids will drain out instead of blocking off the throat and airwaves.
   - Do not be frightened if a person having a seizure appears to stop breathing momentarily

Partial Non-Convulsive Seizures – Response:

1. **Keep calm. Stay with the person**
   - Do not try to stop the seizure, let the seizure take its course
   - Talk gently and reassure the person that everything is OK and you are there to help
   - The person will be unaware of his/her actions and may or may not hear you
   - Using a light touch, guide the student away from hazards

AFTER ALL TYPES OF SEIZURES (The student will be groggy and disoriented)

- Talk gently to comfort and reassure the person that everything is OK
- Stay with them until they become re-oriented
- Notify the parent/guardian of the seizure

Provide a place where the student can rest before returning to regular activity

Note: School administrators should consider simulating an anaphylatic emergency, with all staff, similar to a fire drill, to review and check to see that all elements of the school's emergency protocol are in place and everyone knows their role.

Field Trips and Students with Epilepsy/Seizure Disorder Procedures (Day Trips, Overnight Trips, Extensive Trips, Exchange Programs):

- **Process in place to identify students with Epilepsy/Seizure Disorder.**
- **Trip site and activities are to be checked for potential safety hazards.** Where possible a pre-activity inspection of the site and activities by the in-charge teacher to investigate safety conditions is to be done.
- **Communicate with the child's parents/guardians** during the initial planning stages of the trip informing them of the destination, mode of travel and activities students are to participate in. This will allow for parent/guardian input in the school developing a clear set of expectations and accommodations to meet their child's medical needs on the trip. Knowing the trip expectations and accommodations the parents will be able to provide an informed decision as to their child's participation. You may consider inviting parent on the trip as a supervisor.
- **MEDICATION:** for overnight, extensive or exchange programs **parents are to be consulted on:**
    - Amount, when taken, how it is administered, dosage
    - How medication is to be transported
    - How medication is to be stored
- **Tour operator and/or activity provider:**
    - In-charge teacher to provide tour operator/activity provider with list of students that need to be accommodated on the trip for epilepsy/seizure disorder.
    - Request operator to provide you with their plans and procedures as to how they are going to accommodate for students with epilepsy/seizure disorder.
    - Compare tour operator's plans for accommodations with school board expectations for accommodations for its students.
    - Adjust operator's accommodation plans accordingly to the needs of the student. Follow the plans wherever there is a higher standard.
    - If trip provider does not have a pre-existing plan for the student's medical condition, develop one of your own based on school board expectations and parent input and provide the operator with a copy.
    - Based on list of accommodations for the student the tour operator must provide:
        - Safe accommodations during travel to destination
        - Safe facilities, safe programming, safe foods at the destination
        - Ready access to a doctor, clinic or hospital at destination site
- **An emergency action plan for Epilepsy/Seizure Disorder** on the trip must be prepared by the in-charge teacher and communicated to all staff and volunteers on the trip.
- **Student forms on the trip –** copy of the student's Epilepsy/Seizure Disorder Plan of Care along with trip accommodations, where appropriate, are to be taken on the trip.
- **Grouping of student(s)**: student is to assigned to a group with staff member who is knowledgeable about managing seizures.
- **Buddy system:** In situations where the teacher/supervisor is providing 'in the area supervision' the teacher is to assign a buddy to the student. The 'buddy's' responsibility is to assist the student and to access the teacher supervisors in case of an emergency.
- **A suitable means of communication** (e.g. cell phone) to be taken on the trip and/or an easily accessible phone is available at the site. Ensure that you have the correct and proper change if using payphones.
- **Trip supervisors to meet students** ahead of time who have epilepsy and provide the following information:
    - Never go off alone (e.g. washroom) if they are feeling unwell or about to have a seizure. Always inform an adult ('buddy') on the trip.

- Communicate clearly to adults/those in authority on the trip that he/she has a seizure disorder, when feeling the reaction or generally feeling unwell.

Responsibilities of Parents/Guardians with School:
In order for School Staff to provide a safe and nuturing environment for students managing their Epilepsy Parents/Guardians are asked to:

- **Provide Proof of Diagnosis for your child which can be ONE of**:
    - A letter/note from the physician or specialist, OR
    - A copy/photocopy of the prescription, OR
    - A photocoy of the prescription from the medicine container, OR
    - A copy/photcopy of the Offical Receipt of the medication from the pharmacist
- **COMPLETE and return the following forms found in this package:**
    - **STUDENT PLAN OF CARE**
        - Parents/Guardians of newly registered or newly diagnosed students shall create the Student Plan of Care in consultation with School Adminstration during September or as soon as possible to starting the school year. For students already registered, **the Student Plan of Care should be reviewed and/or updated annually and shared with the school, before the start of each school year.**
    - **CONSENT FORM TO CARRY AND ADMINISTER MEDICATION/DISCLOSE PERSONAL INFORMATION**
        - Form is completed by Parent/Guardian to carry and self-administer medication. Also includes consent to share life-threatening condition with pertinent individuals.

Please Note – Urgency of Having Completed Forms as Soon as Possible:
To act in the best interest of your child responding to a seizure, you are strongly encouraged to provide all relevant information and forms to manage your child's Epilepsy to the school principal in a timely manner. Failure to do so may place your child at unnecessary risk.

- **Provide Information about:**
    - Types of seizures
    - Triggers for your child's seizure e.g. strobe lights
    - Warning signs e.g. 'auras' or other indicators that a seizure might occur
    - Recommend procedures to follow during seizure and first aid required
    - Determine when parent/guardian emergency contact is to be made
    - Determine when 911 ambulance is to be called
    - Medications taken by the student, if/when taken at school and any side effects
    - If your child experiences incontinence and/or enuresis during a seizure, provide your child's classroom with a pillow, blanket and a change of clothes
    - Post seizure symptoms or behaviours

- **UPDATE Changes of information: Emergency Contact, Medication, Medical Diagnosis**:
    - Parents are responsible to inform School Adminstration of any changes to contact information, medication or medical condition diagnosis as soon as reasonably possible. Forms can be accessed through the school office.

NOTE: Changes to your child's diagnosis must be accompanied by a note/letter from your chlid's physician indicating the change.

Please Note: Board employees are not trained health professionals

- **COMMUNICATE, when your child is transitioning to a new school, with the new school in June.**
  You should ask for a most recent copy of your child's Epilepsy/Seizure Disroder Student Plan of Care. You are requested to update the form with recent medical and contact information and to provide the completed form to the receiving school administrator/designate during a transition meeting.

Responsibilities of Parent/Guardian with Child:

- Provide age appropriate information on the causes, identification, prevention and treatment of seizures
- Inform child of the importance of carrying medical information about their medical condition and their medications as directed by the child's health care professional.
- Supply child and/or school with sufficient quantities of medication in an original, clearly labelled container, tracking the expiration dates.
- Guide and encourage child to self-management and self-advocacy.
- Inform child that when they are having a seizure, never remove themselves to a secluded area or go off to be by themselves (e.g. washroom) and to tell a teacher, staff member or a classmate when feeling a reaction or when feeling unwell.
- Encourage child to reach their full potential for self-management and self-advocacy.
- Consider providing a Medical Alert identification for child (e.g. bracelet or necklace). The form can be obtained by calling 1-800-668-1507 or visit www.medicalalert.ca

Responsibilities of Students

- Where appropriate know the causes, symptoms, how to minimize or prevent and the treatment for their epilepsy/seizure disorder
- Advocate for their personal safety and well-being
- Participate in the development and review of their Plan of Care
- Carry out daily or routine self-management of their medical conditions as described in their Plan of Care
- Set goals on an ongoing basis for self-management of their medical condition in conjunction with their parents and healthcare professional
- When feeling unwell or experiencing symptoms of a seizure to not remove themselves to a secluded area or go off by themselves (e.g. washroom). Tell a teacher or classmate that you are experiencing difficulty and need help
- Wear medical alert identification that they and/or their parents/guardians deem appropriate
- If possible, inform school staff and/or peers if a medical incident or emergency occurs
- Communicate with parents/school staff if they are facing challenges related to their Epilepsy/Seizure Disorder, including any, and all, teasing, bullying, threats or any other concerns they have

School Forms

- **STUDENT PLAN OF CARE: EPILEPSY IDENTIFICATION AND EMERGENCY TREATMENT PLAN**
  - To identify child to others, this form will be created from information included in the Student Plan of Care, by the School Adminstrator, and will be shared with appropriate school staff and posted in child's classroom. This form will also be provided to the Sudbury Student Services Transportation Consortium.

    - If the Child's requires an EPI Pen then this form must also be filled out http://www.businfo.ca/en/pdf/forms/F-M04-401%20English%20EpiPen%20Form%20Consortium.pdf
    - The Consortium's Medical Information Form must also be filled in by a medical professional http://www.businfo.ca/en/pdf/forms/F-M04-404%20-%20Medical%20Note.pdf
- **AT-A-GLANCE Medical Disorder IDENTIFICATION**
    - To identify child to others, an At-A-Glance document is created, by the School Adminstrator/Designate, which includes the student's name, grade, picture, and medical condition only and is only posted in pertinent staff areas (i.e. staff room).

- **CONSENT FORM TO CARRY AND ADMINISTER MEDICATION/DISCLOSE PERSONAL INFORMATION**
    - Form is completed by Parent/Guardian to carry and self-administer medication. Also includes consent to share life-threatening condition with pertinent individuals.

TREATMENT PROTOCOLS

Warning Sign: 'AURA'
Some children have a strange sensation before a seizure. This aura acts as a warning that a seizure is about to occur. Sometimes it helps the child to prepare for the seizure by lying down to prevent injury from a fall. The aura varies from one child to another. Children may have a change in body temperature or feeling of anxiety. Some experience a strange taste, striking odour or musical sound. An aura may occur before partial or tonic-clonic seizures. An aura is not always followed by a seizure. In fact, the aura is a simple partial seizure. Ask the child's parent if there are signs of an impending seizure.

Medications
Many seizures may be partly or fully controlled by medication (up to 80%) and there are many drugs available which may control different types of seizures. The challenge is to match the type and dose of medication to the individual and what he/she is experiencing.

The goal is for **one** medication to control the seizure of an individual with negligible side effects. Unfortunately, this is often not the case. Finding a suitable regimen of medication often involves not just one medication, but a combination of two or more meds, each with its own attributes and side effects. In reality, many medications have side effects ranging from nuisance to dangerous.

The process of identifying and balancing the appropriate mix and balance of medications may be one of considerable complexity and could be ongoing over a lengthy period. During the process, there may be uncertainty surrounding seizure control (possibly including different types of seizures) and the accompanying side effects. Patience and ongoing consultation are critical.

Seizure disorders are usually treated with drugs called anti-epileptics or anticonvulsants. These drugs are designed to control seizures. Some drugs control just one type of seizure while others have a broad range. And for some children, these drugs work so well that there are no seizures. For those on these drugs, seizures are eliminated in about 50% of cases. Drugs reduce frequency or intensity of seizures in another 30%. The remaining 20% have seizures that cannot be brought under control by conventional drug therapy.

Some children may experience the following side effects of drug treatments.
- Learning capacity: concentration, short term memory loss
- Alertness: hyperactivity, drowsiness, fatigue
- Motor capacity: hand, eye, balance, speech coordination

- General well-being: unsteadiness, vomiting, dizziness
- Mood changes: depression, aggressiveness, antisocial behaviours
- Toxicity: liver damage, anaemia

Diet as a treatment
The Ketogenic diet is used to treat a small number of children with intractable epilepsy who do not respond to standard therapies. It is an extreme, multi year, high-fat diet that is challenging to administer and maintain. There is no way to predict whether it will be successful, but a significant percentage of children who are placed on the ketogenic diet achieve significant reduction in intensity and frequency of seizures. This type of diet is physician-monitored.

Brain Surgery
Brain surgery for epilepsy is performed, but only in a small percentage of cases, and only when all other treatment fail to adequately control seizures. The last decade has seen significant advances in the surgical treatment of epilepsy. The area of the brain with abnormally discharging neurons (the seizure focus) is surgically removed, if it is possible to identify this area and remove it safely. In certain patients without a well-defined epilepsy focus, surgically disconnecting or isolating the abnormal area so that the seizures no longer spread to the neighbouring normal brain can help. As with any operation, there are risks to epilepsy surgery. In patients with an identified seizure focus, the success rate for surgery is up to 80%. For some children who experience seizures, their seizure activity may occur/increase with times of stress e.g. illness, fever, fatigue, dehydration, heat, right and/or flashing lights.

Vagus Nerve Stimulation Therapy
The vagus nerve stilumator has been approved to treat hard to control seizures. The device is a small, pacemaker-like generator, which is surgically implanted near the collarbone to deliver small bursts of electrical energy to the brain via the vagus nerve in the neck. So far, research has shown that that vagus nerve stimulation may reduce seizures by at least 50% in about half the study participants.

PREVALENT MEDICAL CONDITION — EPILEPSY - PLAN OF CARE		
STUDENT INFORMATION		
Student Name _____	Date of Birth _____	Student Photo
Ontario Ed. # _____	Age _____	
Grade _____	Teacher(s)/Courses _____	

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

Has an emergency rescue medication been prescribed? ☐ Yes ☐ No

If yes, attach the rescue medication plan, healthcare providers' orders and authorization from the student's parent(s)/guardian(s) for a trained person to administer the medication.

Note: Rescue medication training for the prescribed rescue medication and route of administration (e.g. buccal or intranasal) must be done in collaboration with a regulated healthcare professional.

KNOWN SEIZURE TRIGGERS

CHECK (✓) ALL THOSE THAT APPLY

☐ Stress	☐ Menstrual Cycle	☐ Inactivity
☐ Changes in Diet	☐ Lack of Sleep	☐ Electronic Stimulation (TV, Videos, Florescent Lights)
☐ Illness	☐ Improper Medication Balance	
☐ Change in Weather	☐ Other _____	

☐ Any Other Medical Condition or Allergy? _____

_____

DAILY/ROUTINE EPILEPSY MANAGEMENT	
DESCRIPTION OF SEIZURE (NON-CONVULSIVE)	**ACTION:**
	(e.g. description of dietary therapy, risks to be mitigated, trigger avoidance.)
DESCRIPTION OF SEIZURE (CONVULSIVE)	**ACTION:**

SEIZURE MANAGEMENT	
Note: It is possible for a student to have more than one seizure type. Record information for each seizure type.	
SEIZURE TYPE	**ACTIONS TO TAKE DURING SEIZURE**
(e.g. tonic-clonic, absence, simple partial, complex partial, atonic, myoclonic, infantile spasms) Type: _____ Description: _____	

Frequency of seizure activity: _____

_____

Typical seizure duration: _____

BASIC FIRST AID: CARE AND COMFORT

First aid procedure(s): _____

_____

Does student need to leave classroom after a seizure? ❒ Yes ❒ No

If yes, describe process for returning student to classroom: _____

_____

BASIC SEIZURE FIRST AID

- Stay calm and track time and duration of seizure
- Keep student safe
- Do not restrain or interfere with student's movements
- Do not put anything in student's mouth
- Stay with student until fully conscious

FOR TONIC-CLONIC SEIZURE:

Protect student's head
Keep airway open/watch breathing
Turn student on side

EMERGENCY PROCEDURES

Students with epilepsy will typically experience seizures as a result of their medical condition.
Call 9-1-1 when:

- Convulsive (tonic-clonic) seizure lasts longer than five (5) minutes.
- Student has repeated seizures without regaining consciousness.
- Student is injured or has diabetes.
- Student has a first-time seizure.
- Student has breathing difficulties.
- Student has a seizure in water

✸Always notify parent(s)/guardian(s) or emergency contact.

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____

Special Instructions/Notes/Prescription Labels:

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.
✸This information may remain on file if there are no changes to the student's medical condition. See Plan Renewal

PLAN

This plan remains in effect for the 20___— 20___ school year without change and will be reviewed on or before: _____. (It is the parent(s)/guardian(s) responsibility to notify the principal if there is a need to change the plan of care during the school year).

Parent(s)/Guardian(s): _____ Date: _____
Signature

Student: _____ Date: _____
Signature

Principal: _____ Date: _____
Signature

PLAN REVIEW

Where there is no change in the child's condition or treatment strategy from the previous year(s), parents may authorize continuation of the protocol with initials below.

☐ There has been no change in condition or treatment strategy from previous year. Parent initial: _____
Date: _____

☐ There has been no change in condition or treatment strategy from previous year. Parent initial: _____
Date: _____

☐ There has been no change in condition or treatment strategy from previous year. Parent initial: _____
Date: _____

CONSENT FORM
TO CARRY AND ADMINISTER MEDICATION/DISCLOSE PERSONAL INFORMATION

TO BE SIGNED BY PARENT/GUARDIAN UNLESS THE STUDENT IS 18 YEARS OF AGE OR OLDER

ADMINISTRATION OF MEDICATION

In the event of my child _____ experiencing a medical emergency, I consent to the administration of _____ (specify type of medication) by an employee of the Sudbury Catholic District School Board as prescribed by the physician and outlined in the Emergency Procedures of the Prevalent Medical Conditions Policy/Administrative Procedure.

PLEASE PRINT Student's Name: _____ Name of Parent/Guardian: _____ Signature of Parent/Guardian: _____ Signature of Student (if 18 or older): _____	Class/Teachers' Names: Date: _____ Date: _____

MAINTENANCE OF MEDICATION

I understand that it is the responsibility of my child _____to carry _____ (specify type of medication) on his/her person.

PLEASE PRINT Student's Name: _____ Name of Parent/Guardian: _____ Signature of Parent/Guardian: _____ Signature of Student (if 18 or older): _____ Name of Physician: _____	Class/Teachers' Names: Date: _____ Date: _____ Contact # _____

COLLECTION, DISCLOSURE AND USE OF PERSONAL INFORMATION

Authorization for the collection and maintenance of the personal information recorded on the Prevalent Medical Conditions form is the Municipal Freedom of Information and the Protection of Privacy Act. Users of this information should be directed by the principal of the school.

OPTIONAL:

Additionally, I further consent to the disclosure and use of the personal information collected herein to persons, including persons who are not the employees of the Sudbury Catholic District School Board through the posting of photographs and medical information of my child (Plan of Care/Emergency Procedures) in the following key locations:

☐ Classroom	☐ Staffroom	☐ Lunchroom
☐ Office	☐ Gym	☐ Learning Commons/Library
☐ Other: _____	☐ Other: _____	

and through the provision of personal information contained herein to the following persons who are not employees of the Board: please check (✓) all applicable boxes

☐ Food Service Providers	☐ Child Care Providers
☐ School Volunteers in regular direct contact with child	☐ Other: _____

Signature of Parent/Guardian: _____	Date: _____
Signature of Student (if 18 or older): _____	Date: _____
Signature of Principal: _____	Date: _____

We release the Sudbury Catholic District School Board, its employees and agents from any and all liability for loss, damage or injury, howsoever caused to my/our child's person, or property, or to me/us as a consequence, arising from administering the interventions, failing to correctly administer the interventions and/or failing to administer any intervention listed in Epilepsy/Seizure Disorder Student Plan of Care.

Signature of Parent/Guardian: _____	Date: _____
Signature of Student (if 18 or older): _____	Date: _____

PLEASE NOTE THIS CONSENT EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR

This information is collected pursuant to s. 170 and s.265(1)i) of the Education Act, R.S.O. 1990, c. E-2 and s.28(2), 29, 30, 31,32 and 33 of the Municipal Freedom of Information and Protection of Privacy act, R.S.O. 1990, c. M-56: and the Personal Health Information Protection Act, 2004, S.O. 2004, c.3, Sch. A.
If you have any questions regarding your child's personal information, please contact the Principal of your child's school.

AT-A-GLANCE Medical Condition IDENTIFICATION

Student Name	Grade	Medical Condition	Picture (If avaialble)

MEDICAL INCIDENT RECORD FORM						
Student Name	Time of Incident	Length of Incident	Events before Incident	Description of Incident	Events after Incident	Date/Time Parent/Gaurdian Contacted

SUDBURY CATHOLIC DISTRICT SCHOOL BOARD

Appendix E: Concussion Protocol

PREAMBLE

Concussion Safety enacted by the Ontario Legislature came into force March, 2018. The act states that every school board shall establish and maintain a concussion policy which includes: concussion awareness, protocols for removal-from sport, return to sport and a concussion code of conduct for all those involved.

Concussions may limit children's learning opportunities and can cause many nights of interrupted sleep, several days of limited activity, and disruptions in normal activities of life. All these factors influence how children behave and learn at school.
This protocol:

- ensures the safe removal from activity of any student with a suspected concussion in the interest of the student's health and safety.
- recognizes that the school environment and the activities students perform at school, such as concentrating and learning new skills, can worsen a student's concussion symptoms. Many students will require accommodations as they are recovering.
- recognizes that concussion symptoms can have a significant impact on a student's cognitive and physical abilities, thus affecting their school performance.
- identifies that It is equally important to develop strategies to assist students as they "return to school" in the classroom, as it is to develop strategies to assist them as they "return to physical activity". If these are not managed appropriately, a student may have prolonged recovery.

IMPLEMENTATION

What is a Concussion?
A concussion:

- is a form of traumatic brain injury that affects how the brain functions, leading to signs and symptoms that can emerge immediately or in the hours after the injury. It is possible for symptoms to take up to 7 days to appear.
- may be caused by an impact to the head, face, or neck, or an impact to the body that jars the head and causes the brain to move rapidly within the skull.
- cannot be seen on X-rays, standard CT scans or MRIs.
- can occur even if there has been no loss of consciousness. In fact, most concussions occur without a loss of consciousness.
- may have signs and symptoms that are physical (e.g., headache, dizziness), cognitive (e.g., difficulty concentrating or remembering), emotional or behavioural (e.g., depression, irritability), and/or related to sleep (e.g., drowsiness, difficulty falling asleep).
- is typically expected to last one to four weeks in children and youth (under 18 years), but in some cases symptoms may last longer.

For an interactive visualization of how different types of impacts might cause concussion, visit: https://www.hockeycanada.ca/en-ca/hockey-programs/safety/concussions/facts-and-prevention and choose "How a Concussion occurs" or a direct link:
https://cdn.hockeycanada.ca/hockey-canada/Hockey-Programs/Safety/Concussion/Infographic/english.html

The most recent research indicates that prolonged rest until all concussion symptoms resolve is not beneficial and may even prolong recovery. After a short period of rest, students should begin a gradual return back to daily activities, school, and physical activity. **Schools, students, parents/guardians, and healthcare professionals must work together to support a student's effective return to cognitive and physical activity**.

Diagnosis of Concussion

Only medical doctors and nurse practitioners are qualified to provide a concussion diagnosis. All students with a suspected concussion should undergo evaluation by a medical professional. In rural or northern regions, the Medical Assessment may be completed by a nurse with pre-arranged access to a medical doctor or nurse practitioner.

It is important to note that staff at Sudbury Catholic are not medical personnel, as such all supected concussions will be refered to the medical professionals for diagnosis, monitoring and creating return to school or return to physical activity plan.

1. Education and Prevention

Any time a student is involved in physical activity, there is a chance of sustaining a concussion. Therefore, it is important to encourage a culture of safety mindedness and take a preventative approach when students are physically active.
Concussion awareness is important. Annual concussion education to all stakeholders responsible for student safety should include information on:

- the definition and seriousness of concussion;
- possible mechanisms of injury;
- common signs and symptoms;
- steps that can be taken to prevent concussions and other injuries from occurring at school sand at off-site events;
- what to do when a student has suffered a suspected concussion or more serious head injury (i.e., safe removal of an injured student, obtaining proper Medical Assessment);
- what measures should be taken to ensure proper medical assessment;
- management for a diagnosed concussion, including the Return to School and Return to Physical Activity Plans; and,
- Return to Physical Activity Medical Clearance requirements.

A sample lesson has been provided Appendix G

Every student athlete and their parent/guardian sign Appendix I -Education for Athletes and Guardians- to acknlowege that they are aware of Concussions, symptoms and the stages that must be followed once a concussion is diagnosed.

The injury prevention approach to concussion includes primary, secondary, and tertiary strategies:

- **Primary** – information/actions that prevent concussions from happening (e.g., rules and regulations, minimizing slips and falls by ensuring activity environments provide for safe traction and are obstacle-free).
- **Secondary** – appropriate management to prevent the worsening of a concussion (e.g., removal from activity, gradual return to school).
- **Tertiary** – strategies to help prevent long-term complications, such as advising a participant to permanently discontinue a physical activity/sport based on evidence-based guidelines.

Please refer to Appendix F, Concussion Prevention Strategies

2. Recognition and Initial Response

- All stakeholders (e.g., school administrators, teachers, coaches, school first aiders, students) are responsible for the recognition and reporting of students who demonstrate observable signs and/or report symptoms of a concussion.

The recognition component includes the following:

a) **Recognition** and safe removal of an injured student with a suspected concussion;
b) **Initial response** when a suspected concussion is recognized;
c) Steps to take **when no signs or symptoms are identified**, but a possible concussion-causing event was recognized.

a) **Recognition**

A concussion should be suspected:

- in any student who sustains a significant impact to the head, face, neck, or body and demonstrates ANY of the visual signs of a suspected concussion or reports ANY symptoms of a suspected concussion as detailed in the Concussion Recognition Tool (see Appendix A), or
- if a student reports ANY concussion symptoms to one of their peers, parents, teachers, or coaches, or if anyone witnesses an athlete exhibiting any of the visual signs of concussion.

Tools for concussion recognition can be found in Appendix A

Following a significant impact to the head, face, neck, or body, that is either observed or reported, and where the individual responsible for that student (e.g., teacher/coach) suspects a possible concussion, the following immediate actions should be taken:

- Remove the student from participation. The student must not return to physical activity that day.
- Initiate the school's Emergency Action Plan (e.g., basic principles of first aid).

Next, the student should be checked for Red Flag symptoms or other signs and symptoms of concussion.

Step 1: Check for Red Flag signs and/or symptoms.

Red Flag signs and symptoms include:

•Neck pain or tenderness
•Severe or increasing headache
•Deteriorating conscious state
•Double vision
•Seizure or convulsion
•Vomiting
•Weakness or tingling/burning in arms or legs
•Loss of consciousness
•Increasingly restless, agitated, or combative

If any Red Flag signs or symptoms are present, this may indicate a more serious injury.
Follow the Red Flag Procedure.

Red Flag Procedure:

- Call 911.
- If there has been any loss of consciousness, assume there is a possible neck injury and do not move the student.
- Stay with the student until emergency medical services arrive.
- Contact the student's parents/guardians (or emergency contact) to inform them of the incident and that emergency medical services have been contacted.
- Monitor and document any changes in the student (i.e., physical, cognitive, emotional/behavioural).
- If the student has lost consciousness and regains consciousness, encourage them to remain calm and to lie still.
- Do not administer medication unless the student requires it for a health condition (e.g., insulin for a student with diabetes, inhaler for asthma).
- Refer to your school board's injury report form for documentation procedures.

Step 2: If there are NO Red Flags, check for other signs and/or symptoms.

- Remove the student from the current activity or game if the student can be safely moved. Observe and question the student to determine if other concussion signs and/or symptoms are present.
- If any one or more signs and/or symptoms are present, a concussion should be suspected. The full check should be completed (including the Quick Memory Function Check) to provide comprehensive information to the student's parent/guardian and medical doctor/nurse practitioner.
- If any signs or symptoms worsen, or Red Flags emerge, call 911 and follow the Red Flag Procedure as outlined above.

Important Considerations:
• Signs and symptoms can appear immediately after the injury or may take hours to emerge. • Signs and symptoms may be different for each individual student. • A student may be reluctant to report symptoms because of a fear that they will be removed from the activity, their status on a team could be jeopardized, or their academics could be impacted. • It may be difficult for younger students (under the age of 10), students with special needs, or students for whom English/French is not their first language to communicate how they are feeling. • Signs for younger students (under the age of 10) may not be as obvious as in older students. • Memory Function Check Questions may need to be modified for very young students, the situation/activity/sport, or for students receiving special education programs and services.

b) Initial response when a suspected concussion is recognized

The procedures in this section are followed if no Red Flag symptoms are present and one or more concussion signs or symptoms are present (including failing to correctly answer memory check questions).

Response by the responsible teacher, coach, or other supervisor:

- Do not allow the student to return to physical activity/practice/competition that day even if the student states that they are feeling better.
- Do not leave the student alone until a parent/guardian arrives.
- Contact the student's parent/guardian (or emergency contact) to inform them of the incident, that they need to pick up the student and that the student needs urgent Medical Assessment (as soon as possible that day) by a medical doctor or nurse practitioner.
- Monitor and document any changes in the student. If any signs or symptoms worsen, call 911.
- Do not administer medication unless the student requires it for a health condition (e.g., insulin for a student with diabetes, inhaler for asthma).
- The student must not operate a motor vehicle.
- Refer to your school board's injury report form for documentation procedures.

What to provide the parent/guardian:

- Information about the incident and the student's recorded signs and/or symptoms. (For example, the supervising teacher may complete the Tool to Identify a Suspected Concussion and provide a copy to the parent/guardian).
- Documentation of Medical Assessment for completion (see Appendix B).
- The following information:
    - The student needs an urgent Medical Assessment (as soon as possible that day) by a medical doctor or nurse practitioner;
    - The student must be accompanied home by a responsible adult;
    - The student must not be left alone;
    - The parent/guardian needs to communicate to the school principal/designate the results of the Medical Assessment (i.e., that the student does or does not have a diagnosed concussion) prior to the student returning to school.

Responsibilities of the school principal or designate:

• Must inform all school staff (e.g., classroom teachers, physical education teachers, intramural supervisors, coaches) and volunteers* who work with the student that the student shall not participate in any learning or physical activities until the parent/guardian communicates the results of the Medical Assessment to the school principal/designate.

*Prior to communicating with volunteers refer to Administrative Procedure Guideline #HR26 Confidentiality for sharing of student information.

c) Steps to take when no signs or symptoms are identified, but a possible concussion-causing event was recognized

The procedures in this section are followed if no signs or symptoms are observed or reported and the student correctly answers all of the Quick Memory Function Check questions, but the teacher/coach/supervisor recognized that a possible concussion-causing event occurred.

Since signs and/or symptom can emerge hours later, the procedures below are suggested:

Steps followed by the teacher, coach, or other supervisor:

- Contact the student's parent/guardian (or emergency contact) to inform them of the incident.
- Allow the student to remain at school, but do not allow the student to return to physical activity.
- The student must be monitored by school staff for delayed signs and/or symptoms.
- If any signs and/or symptoms (observed or reported) emerge during the school day, the student's parent/guardian must be informed that the student needs an urgent Medical Assessment (as soon as possible that day).
- After 24 hours under observation, if the student has not shown any signs and/or symptoms, they may resume physical activity without Medical Clearance.

What to provide the parent/guardian:
The following information:

- the student can attend school but cannot participate in any physical activity for a minimum of 24 hours;
- the student will be monitored following the incident for 24 hours (at school and home) for the emergence of signs and/or symptoms. Continued observation by the parent/guardian beyond 24 hours may be necessary as signs and/or symptoms can take up to 7 days to emerge;
- if any signs and/or symptoms emerge (observed or reported), the student needs an urgent Medical Assessment (as soon as possible that day) by a medical doctor or nurse practitioner; and
- if after 24 hours of observation, no signs and/or symptoms emerge, the student may return to physical activity and Medical Clearance is not required.

Responsibilities of the School Principal/Designate:

The school principal/designate must inform all school staff (e.g., classroom teachers, physical education teachers, intramural supervisors, coaches) and volunteers* who work with the student that:

- the student is allowed to attend school
- the student must not participate in physical activity and must be monitored for 24 hours for the emergence of delayed signs and/or symptoms.
- if any signs and/or symptoms emerge, the parent/guardian must be informed that the student needs an urgent Medical Assessment (as soon as possible that day) by a medical doctor or nurse practitioner.
- if no signs and/or symptoms emerge, the student is permitted to resume physical activity after 24 hours and Medical Clearance is not required.

**Prior to communicating with volunteers refer to Administrative Procedure Guideline #HR26 Confidentiality for sharing of student information.*

3. Management: Return to School and Return to Physical Activity after a Diagnosed Concussion
Students with a suspected concussion must be assessed by a medical doctor or nurse practitioner as soon as reasonably possible. The parent/guardian must communicate to the school the results of the Medical Assessment.
See Appendix B, Documentation of Medical Assessment

If a concussion is not diagnosed, the student may resume full participation in learning and physical activity with no restrictions.

If a concussion is diagnosed, the student follows a medically-supervised, individualized, and gradual Return to School (RTS) and Return to Physical Activity (RTPA) Plan.

The Return to School and Return to Physical Activity Plan
Knowledge of how to properly manage a diagnosed concussion is critical in a student's recovery and is essential in helping to prevent the student from returning to school or unrestricted physical activities too soon and risking further complications. Ultimately, this awareness and knowledge could help contribute to the student's long-term health and academic success.
The Return to School and Return to Physical Activity Plan (Appendix D) is adapted from the Return-to- School and Return-to-Sport Strategies developed by McCrory et al, 2017.

Return to School and Return to Physical Activity Stages
The stages of the RTS and RTPA Plan are outlined below. In this approach:

- Each stage is a minimum of 24 hours.
- The student moves on to the next stage when they can tolerate activities with no new or worsening symptoms.
- If at any stage the student's symptoms reappear or worsen, or new symptoms emerge, the student should go back to the previous stage for at least 24 hours.
- The stages of RTS must be successfully completed and medical clearance obtained before the student can move on to Stages 5 and 6 of physical activity. At this point, the student should be symptom-free. If symptoms reappear after medical clearance, the student should return to their medical doctor or nurse practitioner for reassessment.
- The RTS and RTPA Stages are interrelated, but not interdependent. That is, a student can be at different stages of RTS and of RTPA at any given time.
- Different students will progress at different rates.
- This information is provided for school administrators and school collaborative teams to use in the management of a student's return to school and return to physical activity following a diagnosed concussion. It does not replace medical advice.

Return to School (RTS) Stages	Return to Physical Activity (RTPA) Stages
Initial Rest at Home	
Relative cognitive rest for 24-48 hours or until symptoms start to improve (whichever occurs first).	Relative physical rest for 24-48 hours or until symptoms start to improve (whichever occurs first).
Sample activities (if tolerated by student):	
✓ Short board/card games ✓ Short phone calls ✓ Photography (with camera) ✓ Crafts	✓ Moving to various locations in the home ✓ Daily hygiene activities ✓ Other limited movement that does not increase heart rate or break a sweat
Activities that are limited at this stage (depending on symptom tolerance): × TV × Technology use (e.g., computer, laptop, tablet, iPad), cell phone use (e.g., texting, games, photography) × Video games × Reading	**Activities not permitted:** × Physical exertion (increases breathing or heart rate, causes sweating) × Stair climbing other than to move locations throughout the home × Sports/sporting activity
Activities not permitted: × Attendance at school or school-type work	

RTS – Stage 1 at Home Light cognitive (thinking/memory/ knowledge) activities. Gradually increase cognitive activity up to 30 minutes. Take frequent breaks. **Activities permitted (if tolerated by student):** ✓ Activities from the previous stage ✓ Easy reading (e.g., books, magazines, newspaper) ✓ Limited TV	**RTPA – Stage 1 at Home** Light physical activities that do not provoke symptoms. Movements that can be done with little effort (do not increase breathing or heart rate, or cause sweating). **Activities permitted (if tolerated by student):** ✓ Daily household tasks (e.g., bed-making, dishes, feeding pets, meal preparation) ✓ Slow walking for a short time

✓ Limited cellphone conversations ✓ Drawing/building blocks/puzzles ✓ Some contact with friends **Activities that are limited at this stage (depending on symptom tolerance):** × Technology use (e.g., computer, laptop, tablet, iPad/cell phone) **Activities not permitted:** × Attendance at school or school-type work	**Activities not permitted:** × Physical exertion (increases breathing and heart rate and sweating) × Sports/sporting activity × Stair climbing, other than to move locations throughout the home
RTS – Stage 2 at Home Gradually add cognitive activity. When light cognitive activity is tolerated, introduce school work at home (facilitated by the school). **Activities permitted (if tolerated by student):** ✓ Activities from the previous stage ✓ School-type work in 30-minute increments ✓ Crosswords, word puzzles, Sudoku, word search ✓ Limited technology use (e.g., computer, laptop, tablet, iPad)/cell phone (e.g., texting/games/photography) starting with shorter periods and building up as tolerated **Activities not permitted:** × School attendance	**RTPA – Stage 2a*** Add additional movements that do not increase breathing and/or heart rate or break a sweat. **Activities permitted (if tolerated by student):** ✓ Activities from the previous stage ✓ Light physical activity (e.g., use of stairs) ✓ 10-15 minutes slow walking 1-2x per day inside and outside **Activities not permitted:** × Physical exertion (increases breathing and/or heart rate and sweating) × Sports × Sporting activities **The student may be at home or at school by this stage, depending on their individual case and the school/school board policy.*
The student is ready to begin school attendance as described in RTS Stage 3.	**RTPA- Stage 2b*** **Activities permitted (if tolerated by student):** ✓ Activities from the previous stage ✓ 20-30 minutes walking/stationary cycling/recreational (i.e., at a pace that causes some increase in breathing/heart rate but not enough to prevent a student from carrying on a conversation comfortably). **Activities not permitted:** × Resistance or weight training × Physical activities with others × Physical activities using equipment **The student may be at home or at school by this stage, depending on their individual case and the school/school board policy*
RTS – Stage 3a Part-time school attendance. The individual RTS Plan is developed by the Collaborative Team following the student conference and assessment of the student's individual needs, determining possible modifications/adaptations for student learning. **Activities permitted (if tolerated by student):** ✓ Activities from the previous stage ✓ School work for up to 2 hours per day in smaller chunks (completed at school) working up to a half day of cognitive activity	**RTPA – Stage 3** Simple locomotor activities and sport-specific exercise to add movement. **Activities permitted (if tolerated by student):** ✓ Activities from the previous stage ✓ Simple individual drills in predictable and controlled environments with no risk of re- injury (e.g., running or throwing drills, skating drills in hockey, shooting drills in basketball). ✓ Restricted recess activities (e.g., walking)

Activities not permitted:
- × Tests/exams
- × Homework
- × Music class
- × Assemblies
- × Field trips

RTS – Stage 3b
Part-time school attendance with a gradual increase in school attendance time, increased school work, and a decrease in learning modifications or adaptations.

Activities permitted (if tolerated by student):
- ✓ Activities from the previous stage
- ✓ School work for 4-5 hours per day, in smaller chunks (e.g., 2-4 days of school/week)
- ✓ Homework up to 30 minutes per day
- ✓ Classroom testing with adaptations

Activities not permitted:
- × Standardized tests/exams

RTS – Stage 4a
Full day school, minimal modifications or adaptations. Nearly normal workload.
- Start to eliminate strategies/approaches
- Increase homework to 60 minutes per day
- Limit routine testing to one test per day with adaptations (e.g., supports - such as more time)

Activities permitted (if tolerated by student):
- ✓ Activities from previous stage
- ✓ Nearly normal cognitive activities
- ✓ Routine school work as tolerated

Activities not permitted:
- × Standardized tests/exams

Activities not permitted:
- × Full participation in physical education or DPA
- × Participation in intramurals
- × Full participation in interschool practices
- × Interschool competitions
- × Resistance or weight training
- × Body contact or head impact activities (e.g., heading a soccer ball)
- × Jarring motions (e.g., high speed stops, hitting a baseball with a bat)

RTPA – Stage 4
Progressively increase physical activity. Add in more difficult non-contact training drills to add coordination and increased thinking.

Activities permitted (if tolerated by student):
- ✓ Activities from the previous stage
- ✓ More complex training drills (e.g., passing drills in soccer and hockey)
- ✓ Physical activity with no body contact (e.g., dance, badminton)
- ✓ Participation in practices for non-contact interschool sports
- ✓ Progressive resistance training may be started
- ✓ Recess – physical activity running/games with no body contact
- ✓ Daily Physical Activity (DPA) (elementary)

Activities not permitted:
- × Full participation in physical education
- × Participation in intramurals
- × Body contact or head impact activities (e.g., heading a soccer ball)
- × Participation in interschool contact sport practices, or interschool games/competitions (non-contact and contact)

RTS – Stage 4b Full day school, no modifications or adaptations. **Activities permitted (if tolerated by student):** ✓ Normal cognitive activities ✓ Routine school work ✓ Full curriculum load (attend all classes, all homework, tests) ✓ Standardized tests/exams ✓ Full extracurricular involvement (non- sport/non-physical activity - e.g., debating club, drama club, chess club)	**Before continuing on to RTPA Stages 5 and 6, the student must:** ☐ **have successfully completed the RTS Plan;** ☐ **have completed RTPA Stages 1 - 4 and be symptom-free; and** ☐ **obtain signed Medical Clearance from a medical doctor or nurse practitioner.** ***Note: Premature return to contact sports (full practice and game play) may cause a significant setback in recovery.***
The Student has successfully completed the Return to School Plan.	**RTPA – Stage 5** Following medical clearance, full participation in all non-contact physical activities (i.e., non- intentional body contact) and in full contact training/practice for contact sports. **Activities permitted:** ✓ Activities from previous stage ✓ Physical Education ✓ DPA (elementary) ✓ Intramural programs ✓ Full participation in non-contact interschool sports ✓ Full contact training/practice in contact interschool sports **Activities not permitted:** × Competition (e.g., games, meets, events) that involves body contact
	RTPA - Stage 6 **Activities permitted:** ✓ Activities from previous stage ✓ Unrestricted return to contact sports. Full participation in games/competition
	The Student has successfully completed the Return to Physical Activity Plan. (Appendix C)

There are two parts to a student's RTS and RTPA Plan. The first part occurs at home and prepares the student for the second part, which occurs at school.

Part I: Home Preparation for Return to School

Initially, a student with concussion requires cognitive and physical rest, followed by stages of progressive cognitive and physical activity which are best accommodated in the home environment.

The home stages of the RTS and RTPA Plan occur under the supervision of the parent/guardian in consultation with the medical doctor or nurse practitioner, and other licensed healthcare professionals involved in the student's clinical care.

The school is not responsible for monitoring this process.

Responsibilities of the School Principal/Designate:
Once the parent/guardian has informed the school principal/designate of the results of the medical assessment, the school principal/designate will then:

- Inform all school staff (e.g., classroom teachers, physical education teachers, intramural supervisors, coaches) and volunteers who work with the student that the student has been diagnosed with a concussion.
- Meet with the parent/guardian and, where appropriate, the student, to:
  - Explain the stages of the RTS and RTPA Plan that occur at home;
  - Explain that the parent/guardian should document the student's progress at home and communicate the student's progress to the school (e.g., using Appendix C).
  - Share information about concussion recovery:
    - Most students who sustain a concussion will make a complete recovery and be able to return to full school and sport/physical activities within 1-4 weeks.
    - Approximately 15-30% of individuals will experience symptoms that persist beyond this time frame.
    - If a student's symptoms are persistent (i.e., last longer than 4 weeks for youth under 18), they may benefit from referral to a medically supervised multidisciplinary concussion clinic.

• Ensure all documentation is filed as per school board administrative procedures and guidelines.

See Appendix C, Documentation for Concussion Management – Home Preparation for Return to School and Return to Physical Activity Plan. This resource outlines the stages of the RTS and RTPA Plan that occur at home and may be used as a communication tool between the parent/guardian and the school.

Part II: The Return to School and Return to Physical Activity Stages at School

When the student is ready to begin attending school again, the following actions are taken by the parent/guardian and the school principal or designate.

Responsibilities of the Parent/Guardian
When the student has successfully completed the stages outlined in Table 1 (Appendix C), the parent/guardian informs the school principal:

- That the student has completed Stages 1 and 2 of the RTS Plan with no new or worsening symptoms and is ready to begin RTS Stage 3 at school.
- What stage the student is currently at in the RTPA Plan (to help guide appropriate participation in physical activity while at school).

Responsibilities of the School Principal/Designate
The principal or designate must meet with the parent/guardian and, where appropriate, the student, to:

- explain the stages of the RTS and RTPA Plan that will occur at school;
- explain that the school and the parent/guardian should continue to communicate about the student's progress (e.g., using Appendix D); and explain the Collaborative Team approach and the parent/guardian's role on the team when the student returns to school.

See Appendix D, Documentation for School Concussion Management –Return to School and Return to Physical Activity Plan. This resource outlines the stages of the RTS and RTPA Plan that occur at school and may be used as a communication tool between the school and parent/guardian.

The Collaborative Team Approach
The management of a student's concussion is a shared responsibility, requiring regular communication between the home, school, and outside sports team (where appropriate), with consultation from the student's medical doctor or nurse practitioner. Other licensed healthcare professionals may play a role in the management of a diagnosed concussion, under the supervision of a medical doctor or nurse practitioner. Examples include physiotherapists, occupational therapists, athletic therapists, and chiropractors.
The school collaborative team plays an important role in a student's recovery. In consultation with the parent/guardian, the team assesses the student's needs and provides learning strategies and modifications to support the student through the stages described earlier.

Led by the school principal/designate, the team should include:

- the injured student;
- the student's parents/guardians;
- teachers and volunteers who work with the student; and
- the medical doctor or nurse practitioner and/or appropriate licensed healthcare professional involved in the student's care.

One **school staff lead** (i.e., a member of the collaborative team, either the school principal/designate, or another staff person designated by the school principal) needs to serve as the main point of contact for the student, the parents/guardians, other school staff, and volunteers who work with the student, and the student's healthcare providers. The designated school staff lead will monitor the student's progress through the Return to School and Return to Physical Activity Plan. Ongoing communication between the parent/guardian and the school collaborative team is essential throughout the process.

The members of the collaborative team must factor in any special circumstances that may affect the setting in which the stages of the RTS and RTPA Plan may occur (i.e., at home and/or school), for example:

- if the student has a diagnosed concussion just prior to winter break, spring break or summer vacation; or
- if the student is neither enrolled in Health and Physical Education class nor participating on a school team.

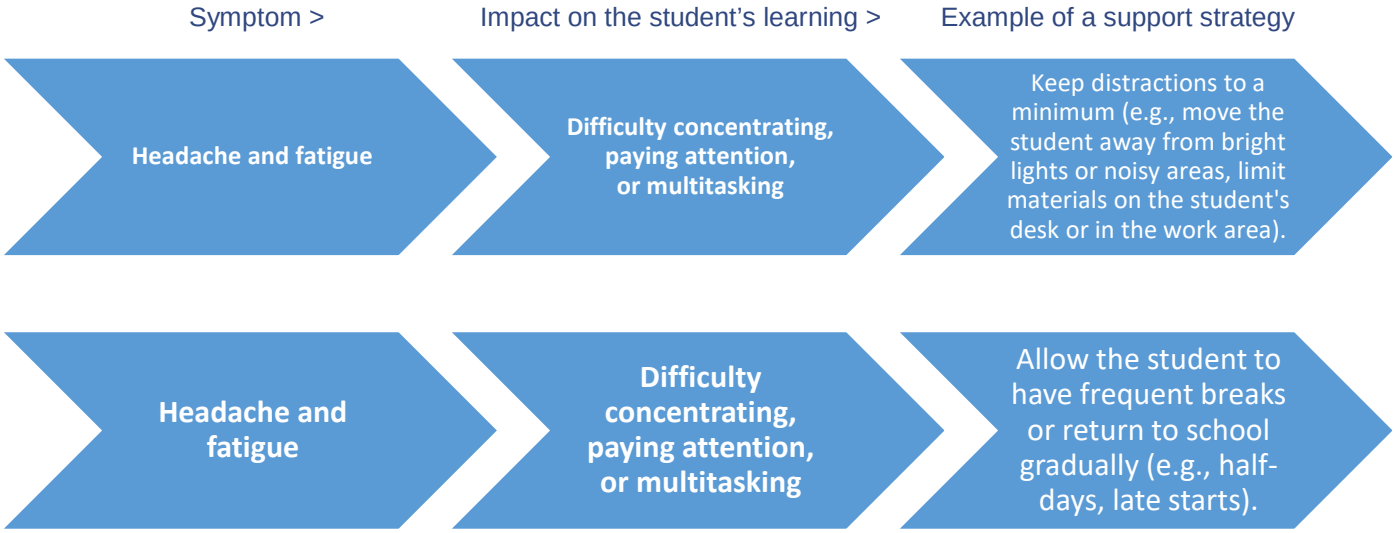
Return to School Support Strategies and Approaches

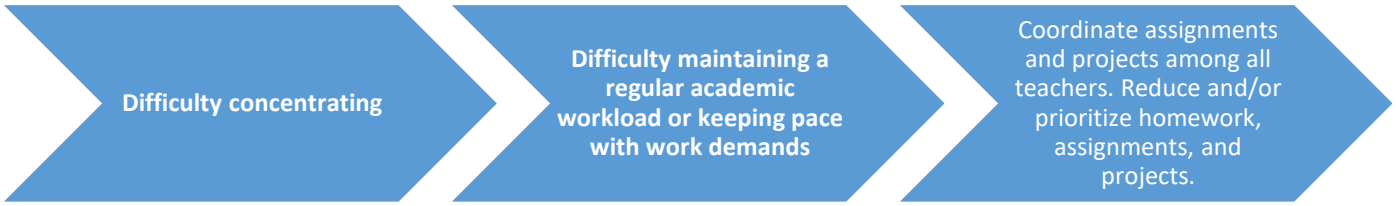
It is important for the designated school staff lead, in consultation with other members of the collaborative team, to identify the student's symptoms and the ways they respond to various
learning activities in order to develop appropriate strategies and/or approaches that meet the changing needs of the student.

School staff and volunteers who work with the student need to be aware of the possible difficulties (i.e., cognitive, emotional/behavioural) a student may encounter when returning to learning activities following a concussion. These difficulties may be subtle and temporary but may significantly impact a student's performance.

Approaches to accommodate students might consider various aspects of the student's school experience, such as the activities the student participates in, the student's course load or timetable, and the physical classroom environment. A few examples are provided below.

Examples of return-to-school support strategies for students experiencing cognitive difficulties:





Examples of return-to-school support strategies for students experiencing emotional and/or behavioural difficulties:

Symptom >	Impact on the student's learning >	Example of a support strategy
Irritability/ frustration	Inappropriate or impulsive behaviour in class	Anticipate and remove the student from problem situations (without characterizing this as punishment)
Anxiety	Overexertion to avoid falling behind at school	Adjust the student's timetable as needed to avoid fatigue. Build in more frequent breaks during the school day.
Irritability/ frustration	Inappropriate or impulsive behaviour in class	consistency on a daily basis. Prepare the student for change and transitions.

For more examples, see Appendix H. Sample Return-to-School Support Strategies and/or Approaches

Medical Clearance (Appendix E)
The student must successfully return to full-time school and receive Medical Clearance before moving on to Stages 5 and 6 of the RTPA Plan, which include full participation in Physical Education, intramural programs, and interschool sport. If, after receiving Medical Clearance, the student's symptoms reappear, the student should be re-evaluated by a medical doctor or nurse practitioner.

The student's parent/guardian should provide the signed Medical Clearance form (Appendix E) to the school principal/designate, and the form should be kept on file (e.g., in the student record).

Chart 1 & 2
The following charts have been provided as a visual quick summary of the procedures.
Chart 1: Identifying a Suspected Concussion – Steps and Responsibilities
Chart 2: Diagnosed Concussion – Stages and Responsibilities

For additional information please refer to:
Appendix J – Concussion Guide for Parents and Caregivers
Appendix K – Strategy for Return to School after a concussion.
Appendix L – Concussion guide for teachers.

References

Ministry of Education Policy/Program Memorandum 158 – School Board Policies on Concussions
Bill 193 – Rowan's
OPHEA – Summary of changes in the Ontario Physical Education Safety Guidelines Concussion Protocol (OPESGCP and Implementation tools, Sept 2018)

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Appendix A
Tool to Identify a Suspected Concussion

This sample checklist tool, completed by school staff (for example, teachers/ coaches/ intramural supervisors), is used to identify the sign(s) and/or symptom(s) of a suspected concussion, to respond appropriately and to communicate this information and follow-up requirements to parent/guardian. This tool may also be used for continued monitoring of the student.

Student name: _____
Time of Incident: _____A.M.☐ P.M.☐
Date: _____

Identification of Suspected Concussion: If after a jarring impact to the head, face or neck or elsewhere on the body, an impulsive force is transmitted to the head (observed or reported), and the individual (for example, teacher/coach) responsible for that student suspects a concussion, the following actions must be taken immediately:

STEP A
Red Flags

Call 911. Check (✓) for Red Flag sign(s) and or symptom(s).
If any one or more red flag sign(s) or symptom(s) are present, call 911, followed by a call to parents/guardians/emergency contact.

- ☐ Neck pain or tenderness
- ☐ Severe or increasing headache
- ☐ Deteriorating conscious state
- ☐ Double vision
- ☐ Seizure or convulsion
- ☐ Vomiting
- ☐ Weakness or tingling/burning in arms or legs
- ☐ Loss of consciousness
- ☐ Increasingly restless, agitated or combative

If Red Flag(s) identified, complete only Step E - Communication to Parent/Guardian.

STEP B
Other Sign(s) and Symptoms(s)
If red flag(s) not identified continue to complete the following steps (as applicable) and Step E - Communication with Parents/Guardians.

STEP B1
Other Concussion Signs
Check (✓) visual cues (what you see).

- ☐ Lying motionless on the playing surface (no loss of consciousness)
- ☐ Disorientation or confusion, or an inability to respond appropriately to questions
- ☐ Balance, gait difficulties, motor un-coordination, stumbling, slow laboured movements
- ☐ Slow to get up after a direct or indirect hit to the head
- ☐ Blank or vacant look
- ☐ Facial injury after head trauma

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STEP B2

Other Concussion Symptoms reported (what the student is saying)

Check (✓) what you feel.

- ☐ Headache
- ☐ Blurred vision
- ☐ More emotional
- ☐ Difficulty concentrating
- ☐ "Pressure in head"
- ☐ Sensitivity to light
- ☐ More irritable
- ☐ Difficulty remembering
- ☐ Balance problems
- ☐ Sensitivity to noise
- ☐ Sadness
- ☐ Feeling slowed down
- ☐ Nausea
- ☐ Fatigue or low energy
- ☐ Nervous or anxious
- ☐ Feeling like "in a fog"
- ☐ Drowsiness
- ☐ "Don't feel right"
- ☐ Dizziness

IF ANY SIGN(S) OR SYMPTOM(S) WORSEN, CALL 911

STEP B3

Conduct Quick Memory Function Check

Questions may need to be modified for very young students, the situation/activity/sport and/or students receiving special education programs and services. Failure to answer any one of these questions correctly indicates a suspected concussion. Record student responses below.

What room are we in right now? *Answer*: _____

What activity/sport/game are we playing now? *Answer*: _____

What field are we playing on today? *Answer*: _____

Is it before or after lunch? *Answer*: _____

What is the name of your teacher/coach? *Answer*: _____

What school do you go to? *Answer*: _____

STEP C

Where sign(s) observed and/or symptom(s) are reported, and/or if the student fails to answer any of the Quick Memory Function questions correctly

Actions Required:

- a concussion should be suspected;
- the student must stop participation immediately and must not be allowed to return to play that day even if the student states that they are feeling better; and
- the student must not:
  - leave the premises without parent/guardian (or emergency contact) supervision;
  - drive a motor vehicle until cleared to do so by a medical doctor or a nurse practitioner;
  - take medications except for life threatening medical conditions (for example, diabetes, asthma).

Teacher/coach to inform parent/guardian that the student needs urgent Medical Assessment (as soon as possible that day) by a medical doctor or nurse practitioner. Medical doctors and nurse practitioners are the only healthcare professionals in Canada with licensed training and expertise to diagnose a concussion; therefore all students with a suspected concussion should undergo evaluation by one of these professionals. In rural or northern regions, the Medical

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Assessment may be completed by a nurse with pre-arranged access to a medical doctor or nurse practitioner.

Parent/guardian must be provided with a completed copy of this form and a copy of Appendix B –Documentation of Medical Assessment. Teacher/coach informs principal of incident.

STEP D

If there are no signs observed, nor symptoms reported, and the student answers correctly all questions in the Quick Memory Function Check but a possible concussion event was recognized by teacher/coach

Actions Required:

• The student must stop participation immediately and must not be allowed to return to play that day even if the student states that they are feeling better. Principals must be informed of the incident.

- Teacher/coach to inform parent/guardian and principal of the incident and that the student requires continued monitoring for 24 hours as sign(s) and or symptom(s) can appear hours or days after the incident:
    - If any red flags emerge call 911 immediately.
    - If any other sign(s) and/or symptom(s) emerge, the student needs urgent Medical Assessment (as soon as possible that day) by a medical doctor or nurse practitioner.
    - Parent/guardian is to communicate the results of the Medical Assessment to the appropriate school personnel using Appendix B –Documentation of Medical Assessment.
    - If after 24 hours of monitoring no sign(s) and or symptom(s) have emerged the parent/guardian is to communicate the results to the appropriate school official using the school's process and/or form. Student is permitted to resume physical activities.

- Medical Clearance is not required.

STEP E

Communication to Parent/Guardian

Summary of Suspected Concussion Check – Indicate (✓) appropriate results and follow-up requirements.

Your child/ward was checked for a suspected concussion (i.e., Red Flags, Other Signs and Symptoms, Quick Memory Function) with the following results:

☐ Red Flag(s) sign(s) observed and/or symptom(s) reported and EMS called.

☐ Other concussion sign(s) were observed and/or symptom(s) reported and or student failed to correctly answer all the Quick Memory Function questions.

☐ No sign(s) or symptom(s) were reported and student correctly answered all of the questions in the Quick Memory Function Check but a possible concussion event was recognized. Continued monitoring is required (see Step D above).

Teacher/Coach/Intramural Supervisor name: _____

Teacher/Coach/Intramural Supervisor signature (optional): _____

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Forms for Parent/Guardian:

- ☐ Appendix B –Documentation of Medical Assessment

Parent/Guardian must communicate to principal/designate results of 24 hour monitoring (using school process/form):

- ☐ Results of Medical Assessment (Appendix B –Documentation of Medical Assessment)
- ☐ No concussion sign(s) and/symptom(s) observed or reported after 24 hours monitoring

If a concussion is diagnosed, then also

- ☐ Appendix C –Home Preparation for Return to School and Return to Physical Activity
- ☐ Appendix D – Return to School and Return to Physical Activity

When Medical Clearance is needed to return to full physical activity

- ☐ Appendix E – Medical Clearance

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Appendix B
Documentation of Medical Assessment

Form is to be provided to a student that demonstrates or reports concussion sign(s) and or symptom(s). For more information consult Appendix A –Tool to Identify a Suspected Concussion.

Student name: _____
Date: _____

The student must be assessed as soon as possible by a medical doctor or nurse practitioner. In Canada, only medical doctors and nurse practitioners are qualified to provide a concussion diagnosis. In rural or northern regions, a nurse with pre-arranged access to a medical doctor or nurse practitioner may be used to assess the suspected concussion. Prior to returning to school, the parent/guardian must inform the school principal of the results of the medical assessment by completing the following:

RESULTS OF MEDICAL ASSESSMENT

☐ My child/ward has been assessed and a concussion has not been diagnosed and therefore may resume full participation in learning and physical activity without any restrictions.

☐ My child/ward has been assessed and a concussion has not been diagnosed but the assessment led to the following diagnosis and recommendations:

_____
_____
_____
_____

☐ My child/ward has been assessed and a concussion has been diagnosed and therefore must begin a medically supervised, individualized, and gradual Return to School (RTS) and Return to Physical Activity (RTPA) Plan. Refer to the reverse side of page for information on the Home Preparation for Return to School (RTS) and Return to Physical Activity (RTPA) Plan.

Comments:

_____
_____
_____
_____

Medical Doctor/Nurse Practitioner providing assessment
Name: _____
Phone Number: _____

Parent/Guardian signature: _____
Date: _____

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HOME PREPARATION FOR RETURN TO SCHOOL (RTS) AND RETURN TO PHYSICAL ACTIVITY (RTPA) PLAN

The RTS and RTPA Plan has been developed in partnership with Parachute and is based on the most recent research and recommendations of the expert scientific community on concussion, that is, The Canadian Guidelines on Concussion in Sport, July 2017 and the Berlin Consensus Statement on Concussion in Sport, October 2016.

Should a student be diagnosed with a concussion, the student will be expected to follow a Return to School (RTS) and Return to Physical Activity (RTPA) Plan. There are two parts to a student's RTS and RTPA Plan. The first begins at home with the Home Preparation for RTS and RTPS Plan (consult Table 1: Student at home).

Table 1: Student is at home

Home Preparation for Return to School (RTS) Stages	**Home Preparation for Return to Physical Activity (RTPA) Stages**
Each stage must last a minimum of 24 hours	
Initial Rest at Home Relative cognitive rest for 24-48 hours or until symptoms start to improve (whichever occurs first).	
RTS – Stage1 Light cognitive (thinking/memory/ knowledge) activities. Gradually increase cognitive activity up to 30 minutes. Take frequent breaks.	**RTPA – Stage1** Light physical activities that do not provoke symptoms. Movements that can be done with little effort (do not increase breathing and/or heart rate or break a sweat).
RTS -Stage 2 Gradually add cognitive activity. When light cognitive activity is tolerated, introduce school work (at home and facilitated by the school).	**RTPA –Stage 2a** Daily activities that do not provoke symptoms. Add additional movements that do not increase breathing and/or heart rate or break a sweat.

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Appendix C
Documentation for Concussion Management - Home Preparation for Return to School (RTS) and Return to Physical Activity (RTPA) Plan

Form is to be used by parents/guardians to track and to communicate to the school a student's progress through the stages of the Home Preparation for Return to School (RTS) and Return to Physical Activity (RTPA) Plan following a diagnosed concussion.

The RTS and RTPA Plan has been developed in partnership with Parachute and is based on the most recent research and recommendations of the expert scientific community on concussion i.e., the Canadian Guidelines on Concussion in Sport, July 2017 and the Berlin Consensus Statement on Concussion in Sport, October 2016.

Student name: _____
Date: _____

BACKGROUND INFORMATION ON THE CONCUSSION RECOVERY PROCESS

A student with a diagnosed concussion needs to follow an individualized and gradual RTS and RTPA Plan. In developing the Plan, the RTS process is individualized to meet the particular needs of the student, as there is not a pre-set plan of strategies and/approaches to assist a student return to their learning activities. In contrast the RTPA Plan follows an internationally recognized graduated approach.

The management of a student concussion is a shared responsibility, requiring regular communication, between the home, school (Collaborative Team) and outside sports team (where appropriate) with consultation from the student's medical doctor or nurse practitioner and/or other licensed healthcare providers (for example, nurses, physiotherapists, chiropractors and athletic therapists).

There are two parts to a student's RTS and RTPA Plan. This first part occurs at home and prepares the student for the second part which occurs at school.

The Home Preparation for RTS and RTPA Plan focuses on a student's progression through the home stages of the RTS and RTPA Plan. It has been designed to provide direction for, and documentation of the stages of the RTS and RTPA Plan.

GENERAL PROCEDURES FOR HOME PREPARATION FOR RTS AND RTPA PLAN

- The stages of the plan occur at home under the supervision of the parent/guardian in consultation with the medical doctor/nurse practitioner and/or other licensed healthcare providers.

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- A student moves forward to the next stage when activities at the current stage are tolerated and the student has not exhibited or reported a return of symptoms, new symptoms, or worsening symptoms.
- If symptoms return, or new symptoms appear at any stage in the Home Preparation for RTS and RTPA Plan, the student returns to previous stage for a minimum of 24 hours and only participates in activities that can be tolerated.
- If at any time symptoms worsen, the student/parent/guardian contacts medical doctor/nurse practitioner or seeks medical help immediately.
- While the RTS and RTPA stages are inter-related they are not interdependent. Students do not have to go through the same stages of RTS and RTPA at the same time. However, before a student can return to school they must have completed RTS Stage 2 and RTPA Stage 2b.
- A student must not return to vigorous or organized physical activities where the risk of re-injury is possible, until they have successfully completed all stages of the Return to School Plan. However early introduction of some low intensity physical activity in controlled and predictable environments with no risk of re-injury is appropriate.
- This Plan does not replace medical advice.
- Progression through the Plan is individual, timelines and activities may vary.

INSTRUCTIONS

- Review the activities (permitted and not permitted) at each stage prior to beginning the Plan.
- Check (✓) the boxes at the completion of each stage to record student's progress through the stages.
- A student may progress through the RTS stages at a faster or slower rate than the RTPA stages.
- When the student has successfully completed all stages of the Home Preparation for RTS and RTPA Plan, parent(s)/guardian(s) must sign and date this form.
- Communicate to the school principal/designate that the student is ready to begin the school portion of the RTS and RTPA Plan.

STUDENT IS AT HOME

TABLE 1: HOME PREPARATION FOR RETURN TO SCHOOL (RTS) AND RETURN TO PHYSICAL ACTIVITY (RTPA) PLAN

Home Preparation for Return to School (RTS) Stages	**Home Preparation for Return to Physical Activity (RTPA) Stages**
Each stage must last a minimum of 24 hours	
Initial Rest at Home	
RTS- Initial Rest 24 – 48 hours of relative cognitive rest (sample activities below):	**RTPA – Initial Rest**

Activities permitted (if tolerated by student): ✓ Short board/card games ✓ Short phone calls ✓ Photography (with camera) ✓ Crafts **Activities that are limited at this stage (depending on symptom tolerance):** × TV × Technology use (e.g., computer, laptop, tablet, iPad/cell phone) (for example, texting/games/photography) × Video games × Reading × Attendance at school or school-type work	24 – 48 hours of relative physical rest (sample activities below): **Activities permitted (if tolerated by student):** ✓ Limited movement that does not increase heart rate or break a sweat ✓ Moving to various locations in the home ✓ Daily hygiene activities **Activities not permitted:** × Physical exertion (increases breathing and/heart rate and sweating) × Stair climbing other than to move locations throughout the home × Sports/sporting activity
Student moves to RTS Stage 1 when: ☐Symptoms start to improve or after resting 2 days maximum, or whichever occurs first.	Student moves to RTPA Stage 1 when: ☐Symptoms start to improve or after resting 2 days maximum, or whichever occurs first.
<u>RTS – Stage 1 at Home</u> Light cognitive (thinking/memory/ knowledge) activities. Gradually increase cognitive activity up to 30 minutes. Take frequent breaks. **Activities permitted (if tolerated by student):** ✓ Activities from the previous stage ✓ Easy reading (e.g., books, magazines, newspaper) ✓ Limited TV ✓ Limited cellphone conversations ✓ Drawing/building blocks/puzzles	**<u>RTPA – Stage 1 at Home</u>** Light physical activities that do not provoke symptoms. Movements that can be done with little effort (do not increase breathing or heart rate, or cause sweating). **Activities permitted (if tolerated by student):** ✓ Daily household tasks (e.g., bed-making, dishes, feeding pets, meal preparation) ✓ Slow walking for a short time **Activities not permitted:**

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✓ Some contact with friends **Activities that are limited at this stage (depending on symptom tolerance):** × Technology use (e.g., computer, laptop, tablet, iPad/cell phone) **Activities not permitted:** × Attendance at school or school-type work	× Physical exertion (increases breathing and heart rate and sweating) × Sports/sporting activity × Stair climbing, other than to move locations throughout the home
Student moves to RTS Stage 2 when: ☐Student tolerates 30 minutes of light cognitive activity (for example a student should be able to complete 3-4 of the permitted activities listed above) and has not exhibited or reported a return of symptoms, new symptoms or worsening symptoms. ☐Student has completed a minimum of 24 hours at RTS – Stage 1. ☐Student has exhibited or reported a return of symptoms, or new symptoms and must return to the previous stage for a minimum of 24 hours. ☐Student has exhibited or reported a worsening of symptoms and must return to medical doctor or nurse practitioner.	**Student moves to RTPA Stage 2 when:** ☐Student tolerates light physical activities (completes both activities above) and has not exhibited or reported a return of symptoms, new symptoms or worsening symptoms. ☐Student has exhibited or reported a worsening of symptoms and must return to medical doctor or nurse practitioner. ☐Student has completed a minimum of 24 hours at RTPA – Stage 1. ☐Student has exhibited or reported a worsening of symptoms and must return to medical doctor or nurse practitioner.
RTS – Stage 2 at Home Gradually add cognitive activity. When light cognitive activity is tolerated, introduce school work at home (facilitated by the school). **Activities permitted (if tolerated by student):** ✓ Activities from the previous stage ✓ School-type work in 30-minute increments ✓ Crosswords, word puzzles, Sudoku, word search ✓ Limited technology use (e.g., computer, laptop, tablet, iPad)/cell phone (e.g., texting/games/photography) starting with shorter periods and building up as tolerated	**RTPA – Stage 2a** Daily activities that do not provoke symptoms. Add additional movements that do not increase breathing and/or heart rate or break a sweat. **Activities permitted (if tolerated by student):** ✓ Activities from the previous stage ✓ Light physical activity (e.g., use of stairs) ✓ 10-15 minutes slow walking 1-2x per day inside and outside **Activities not permitted:** × Physical exertion (increases breathing and/or heart rate and sweating) × Sports × Sporting activities

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Activities not permitted:
- ✗ School attendance

☐Student tolerates the additional cognitive activity (for example a student should be able to complete 3-4 of the activities permitted) and has not exhibited or reported a return of symptoms, new symptoms or worsening symptoms.
☐Student has completed a minimum of 24 hours at RTS – Stage 2.
☐Student has exhibited or reported a return of symptoms, or new symptoms and must return to the previous stage for a minimum of 24 hours.
☐Student has exhibited or reported a worsening of symptoms and must return to medical doctor or nurse practitioner.

**The student may be at home or at school by this stage, depending on their individual case and the school/school board policy.*

Student moves to RTPA Stage 2b when:
☐Student tolerates daily physical activities (completes activities permitted listed above) and has not exhibited or reported a return of symptoms, new symptoms or worsening symptoms.
☐Student has completed a minimum of 24 hours at RTPA – Stage 2a.
☐Student has exhibited or reported a return of symptoms, or new symptoms and must return to the previous stage for a minimum of 24 hours.
☐Student has exhibited or reported a worsening of symptoms and must return to medical doctor or nurse practitioner.

RTPA- Stage 2b

Light aerobic activity

Activities permitted (if tolerated by student):
- ✓ Activities from the previous stage
- ✓ 20-30 minutes walking/stationary cycling/recreational (i.e., at a pace that causes some increase in breathing/heart rate but not enough to prevent a student from carrying on a conversation comfortably).

Activities not permitted:
- ✗ Resistance or weight training
- ✗ Physical activities with others
- ✗ Physical activities using equipment

**The student may be at home or at school by this stage, depending on their individual case and the school/school board policy*

☐Student tolerates light aerobic activities (completes activities above) and has not exhibited or reported a return of symptoms, new symptoms or worsening symptoms.
☐Student has completed a minimum of 24 hours at RTPA – Stage 2b.
☐Student has exhibited or reported a return of symptoms, or new symptoms and must

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return to the previous stage for a minimum of 24 hours. ☐Student has exhibited or reported a worsening of symptoms and must return to medical doctor or nurse practitioner.

Parent/Guardian communicates to school principal (by completing the following information on this form) that the student has completed RTS Stage 2 and RTPA Stage 2b and is ready to return to school and begin the school part of the Return to School and Return to Physical Activity Plan

☐ My child/ward has successfully completed all of the stages of the Home Preparation for Return to School (RTS) and Return to Physical Activity (RTPA) and is ready to return to school

Parent/Guardian Signature: _____

Date: _____

Comments:

_____

_____

_____

_____

_____

The school part of the plan begins with:

- A meeting with the principal/designate to provide information on:
  - the school part of the RTS and RTPA Plan (Appendix D)
  - Collaborative Team participants and parent/guardian role on the team
- A student assessment to determine possible strategies and/or approaches for student learning

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Appendix D
Documentation for School Concussion Management – Return to School (RTS) and Return to Physical Activity (RTPA) Plan

Form is to be used by parents/guardians and the school Collaborative Team to communicate and track a student's progress through the stages of the Return to School and Return to Physical Activity Plan following completion of Home Preparation for Return to School and Return to Physical Activity. The RTS and RTPA Plan is to be used with APG: Concussion Protocol: Prevention, Identification and Management Procedures.

Student name: _____
Date: _____

BACKGROUND INFORMATION ON THE CONCUSSION RECOVERY PROCESS THAT OCCURS AT SCHOOL

A student with a diagnosed concussion needs to follow an individualized and gradual RTS and RTPA Plan. In developing the plan the RTS process is designed to meet the particular needs of the student, as there is not a pre-set plan of strategies and/or approaches to assist a student returning to their learning activities. In contrast the RTPA Plan follows an internationally recognized graduated approach.
The management of a student concussion is a shared responsibility, requiring regular communication, between the home, school (Collaborative Team) and outside sports team (where appropriate) with consultation from the student's medical doctor or nurse practitioner and/or other licensed healthcare providers (for example, nurses, physiotherapists, chiropractors and athletic therapists).

GENERAL PROCEDURES FOR SCHOOL CONCUSSION MANAGEMENT – RETURN TO SCHOOL (RTS) AND RETURN TO PHYSICAL ACTIVITY PLAN (RTPA)

Appendix D focuses on a student's progression through the school stages of the RTS and RTPA Plan. It has been designed to provide direction for, and documentation of the stages of the RTS and RTPA Plan.
The school part of the plan begins with:

- A parent/guardian and principal/designate meeting (for example, in-person, phone conference, video conference, email) to provide information on:
  - The school part of the RTS and RTPA Plan (Appendix D);
  - The Collaborative Team members and their role (for example, parent/guardian, student, principal/designate, team lead, teacher(s), medical doctor or nurse practitioner and/or appropriate licensed healthcare provider).
- A student conference to determine the individualized RTS Plan and to identify:
  - The RTS learning strategies and/or approaches required by the student based on the post-concussion symptoms;
  - The best way to provide opportunities for the permissible activities.

General Procedures for School Concussion Management

- The stages of the General Procedures for School Concussion Management plan occur at school and where appropriate the RTPA part of the plan may occur at sport practices (for example, student is not enrolled in physical education).
- For the student who is a member of an outside sporting team, communication is essential between the parent/guardian/student, outside coach and school.
- Stages are not days – each stage must take a minimum of 24 hours and the length of time needed to complete each stage will vary based on the severity of the concussion and the student.
- Completion of the RTS and RTPA Plan may take 1-4 weeks.
- A student moves forward to the next stage when activities at the current stage are tolerated and the student has not exhibited or reported a return of symptoms, new symptoms, or worsening symptoms.
- A student is tolerating an activity if their symptoms are not exacerbated (aggravated, intensified, made worse).
- While the RTS and RTPA stages are inter-related they are not interdependent. A student's progress through the stages of RTS is independent from their progression through the RTPA stages. However, students must have completed Stage 4a and 4b of RTS and Stage 4 of RTPA and have obtained Medical Clearance prior to beginning Stage 5 of RTPA.
- Until a student has successfully completed all stages in the RTS plan they must not participate in the following physical activities where the risk of re-injury is possible:
    - full participation in the physical education curricular program;
    - intramural activities;
    - full participation in non-contact interschool activities; or
    - participation in practice for a contact sport.
- A student that has no symptoms when they return to school, must progress through all of the RTS stages and RTPA stages and remain symptom free for a minimum of 24 hours in each stage prior to moving to the next stage.
- The Plan does not replace medical advice.
- During all stages of RTS and in Stages 1-4 of RTPA:
    - if symptoms return or new symptoms appear, the student returns to previous stage for a minimum of 24 hours and only participates in activities that can be tolerated.
- During stages 5 and 6 of RTPA:
    - if symptoms return or new symptoms appear, the student must return to medical doctor/nurse practitioner to have the Medical Clearance re-assessed.

- During all stages of RTS and RTPA if symptoms worsen over time, follow school (collaborative team procedures) for contacting parents/guardians to inform them that the student needs a follow-up medical assessment.
- Progression through the Plan is individual, timelines and activities may vary.
- Upon completion of the RTS and RTPA Plan, this form is returned to the principal/designate for filing as per school board's procedures.

Instructions: At each stage, this form (hard copy/electronic) will go back and forth between the school and home.

- Review the activities (permitted and not permitted) at each stage prior to beginning the Plan.
- School (for example, teacher, collaborative team lead) provides appropriate activities and documents student's progress by checking (✓), dating, initialling completion of each stage and communicating information (form) to parent/guardian.
- Within each stage, parent/guardian completes, checks (✓), dates and signs the student's tolerance to those activities (i.e., no returning, new or worsening symptoms) giving permission for the student to progress to the next stage and returns completed form to school.

SCHOOL CONCUSSION MANAGEMENT PLAN

Table 1: School Concussion Management Plan

Return to School (RTS) Stages	Return to Physical Activity (RTPA) Stages
RTS – Stage 3a Student begins with an initial time at school of 2 hours. The individual RTS Plan is developed by the Collaborative Team following the student conference and appraisal of the student's individual needs, determining possible modifications/adaptations for student learning. (consult Table 5 in APG). **Activities permitted if tolerated by student:** ✓ Activities from the previous stage (consult Appendix C –Documentation for Concussion Management – Home Preparation for RTS and RTPA) ✓ School work for up to 2 hours per day in smaller chunks (completed at school) working up to a ½ day of cognitive activity ✓ Learning strategies and/or approaches **Activities not permitted:** × Tests/exams × Homework × Music class × Assemblies × Field trips	**RTPA – Stage 3** Simple locomotor activities and sport-specific exercise to add movement. **Activities permitted if tolerated by student:** ✓ Activities from the previous stage (20-30 minutes walking/stationary cycling/elliptical/recreational dancing at a moderate pace) ✓ Simple individual drills in predictable and controlled environments with no risk of re-injury (e.g., running or throwing drills, skating drills in hockey, shooting drills in basketball). ✓ Restricted recess activities (e.g., walking) **Activities not permitted:** × Full participation in physical education or DPA × Participation in intramurals × Full participation in interschool practices × Interschool competitions × Resistance or weight training

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	✗ Body contact or head impact activities (e.g., heading a soccer ball) ✗ Jarring motions (e.g., high speed stops, hitting a baseball with a bat)
School ☐ Student has demonstrated they can tolerate up to a half day of cognitive activity ☐ Appendix D sent home to parent/guardian School Initial (for example, collaborative team lead/designate): _____ Date: _____	**School** ☐ Student has demonstrated they can tolerate simple individual drills/sport specific drills as listed in permitted activities ☐ Appendix D sent home to parent/guardian School Initial (for example, collaborative team lead/designate): _____ Date: _____
Home ☐ Student has not exhibited or reported a return of symptoms, new symptoms or worsening symptoms and can now progress to RTS Stage 3b. ☐ Student has exhibited or reported a return of symptoms, or new symptoms, and must return to the previous stage for a minimum of 24 hours. ☐ Student has exhibited or reported a worsening of symptoms and must return to medical doctor or nurse practitioner. ☐ Appendix D returned to school Parent/Guardian: Signature: _____ Date:_____ Comments: _____	Home ☐ Student has not exhibited or reported a return of symptoms, new symptoms or worsening symptoms and can now progress to RTPA Stage 4. ☐ Student has exhibited or reported a return of symptoms, or new symptoms, and must return to the previous stage for a minimum of 24 hours. ☐ Student has exhibited or reported a worsening of symptoms and must return to medical doctor or nurse practitioner. ☐ Appendix D returned to school Parent/Guardian: Signature: _____ Date:_____ Comments: _____
RTS - Stage 3b Student continues attending school half time with gradual increase in school attendance time, increased school work, and decrease in adaptation of learning strategies and/or approaches. **Activities permitted (if tolerated by student):** ✓ Activities from the previous stage	

✓ School work for 4-5 hours per day, in smaller chunks (e.g., 2-4 days of school/week) ✓ Homework up to 30 minutes per day ✓ Decrease adaptation of learning strategies and/or approaches ✓ Classroom testing with adaptations **Activities not permitted:** × Standardized tests/exams	
School ☐ Student has demonstrated they can tolerate up to 4-5 hours of the cognitive activities listed above ☐ Appendix D sent home to parent/guardian School Initial (for example, collaborative team lead/designate): _____ Date: _____ **Home** ☐ Student has not exhibited or reported a return of symptoms, new symptoms or worsening symptoms and can now progress to RTS Stage 4a ☐ Student has exhibited or reported a return of symptoms, or new symptoms, and must return to the previous stage for a minimum of 24 hours. ☐ Student has exhibited or reported a worsening of symptoms and must return to medical doctor or nurse practitioner. ☐ Appendix D returned to school Parent/Guardian: Signature: _____ Date:_____ Comments: _____	
RTS – Stage 4a	**RTPA – Stage 4** Progressively increase physical activity.

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Full day at school, minimal adaptation of learning strategies and/or approaches. Nearly normal workload. **Activities permitted if tolerated by student:** ✓ Activities from previous stage ✓ Nearly normal cognitive activities ✓ Routine school work as tolerated ✓ Minimal adaptation of learning strategies and/or approaches ✓ Start to eliminate adaptation of strategies and/or approaches ✓ Increase homework to 60 minutes/day ✓ Limit routine testing to one test per day with adaptations (for example, supports - such as more time) **Activities not permitted:** × Standardized tests/exams	Non-contact training drills to add coordination and increased thinking. **Activities permitted if tolerated by student:** ✓ Activities from the previous stage ✓ More complex training drills (e.g., passing drills in soccer and hockey) ✓ Physical activity with no body contact (e.g., dance, badminton) ✓ Participation in practices for non-contact interschool sports (no contact) ✓ Progressive resistance training may be started ✓ Recess – physical activity running/games with no body contact ✓ Daily Physical Activity (DPA) (elementary) **Activities not permitted:** × Full participation in physical education × Participation in intramurals × Body contact or head impact activities (e.g., heading a soccer ball) × Participation in interschool contact sport practices, or interschool games/competitions (non-contact and contact)
School ☐ Student has demonstrated they can tolerate a full day of school and a nearly normal workload with minimal adaptation of learning strategies and/or approaches ☐ Appendix D sent home to parent/guardian School Initial (for example, collaborative team lead/designate): _____ Date: _____	**School** ☐ Student has completed the activities in RTPA Stage 4 as applicable ☐ Appendix D sent home to parent/guardian ☐ Appendix E – Documentation for Medical Clearance sent home to parent/guardian School Initial (for example, collaborative team lead/designate): _____ Date: _____
Home ☐ Student has not exhibited or reported a return of symptoms, new symptoms or worsening symptoms and can now progress to RTS Stage 4b ☐ Student has exhibited or reported a return of symptoms, or new symptoms, and must return to the previous stage for a minimum of 24 hours.	**Home** ☐ Student has not exhibited or reported a return of symptoms, new symptoms or worsening symptoms ☐ Student has exhibited or reported a return of symptoms, or new symptoms, and must return to the previous stage for a minimum of 24 hours. ☐ Student has exhibited or reported a worsening of symptoms and must return to medical doctor or nurse practitioner.

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☐ Student has exhibited or reported a worsening of symptoms and must return to medical doctor or nurse practitioner. ☐ Appendix D returned to school Parent/Guardian: Signature: _____ Date:_____ Comments: _____	☐ Appendix D returned to school Parent/Guardian: Signature: _____ Date:_____ Comments: _____
RTS – Stage 4b At school: full day, without adaptation of learning strategies and/or approaches. **Activities permitted (if tolerated by student):** ✓ Normal cognitive activities ✓ Routine school work ✓ Full curriculum load (attend all classes, all homework, tests) ✓ Standardized tests/exams ✓ Full extracurricular involvement (non-sport/non-physical activity - e.g., debating club, drama club, chess club)	**Before continuing on to RTPA Stages 5, the student must:** ☐ have completed RTS Stage 4a and 4b (full day at school without adaptions of learning strategies and/or approaches), ☐ have completed RTPA Stage 4 and be symptom-free; and ☐ obtain signed Medical Clearance from a medical doctor or nurse practitioner. ***Note:*** *Premature return to contact sports (full practice and game play) may cause a significant setback in recovery.*
School ☐ Student has demonstrated they can tolerate a full day of school without adaptation of learning strategies and/or approaches ☐ Appendix D sent home to parent/guardian School Initial (for example, collaborative team lead/designate): _____ Date: _____	
Home ☐ Student has not exhibited or reported a return of symptoms, new symptoms or worsening symptoms and has completed the RTS Plan ☐ Student has exhibited or reported a return of symptoms, or new symptoms, and must return to the previous stage for a minimum of 24 hours	

☐ Student has exhibited or reported a worsening of symptoms and must return to medical doctor or nurse practitioner. Parent/Guardian: Signature: _____ Date:_____ Comments: _____	
	RTPA – Stage 5 Following Medical Clearance, full participation in all non-contact physical activities (i.e., non-intentional body contact) and full contact training/practice in contact sports **Activities permitted:** ✓ Activities from previous stage ✓ Physical Education ✓ Intramural programs ✓ Full contact training/practice in contact interschool sports **<u>Activities not permitted:</u>** × Competition (e.g., games, meets, events) that involves body contact
	School ☐ Student has completed the applicable physical activities in RTPA Stage 5 ☐ Appendix D sent home to parent/guardian School Initial (for example, collaborative team lead/designate): _____ Date: _____
	Home ☐ Student has not exhibited or reported a return of symptoms or new symptoms and can progress to RTPA Stage 6

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	☐ Student has exhibited/reported a return of symptoms or new symptoms and must return to medical doctor/nurse practitioner for Medical Clearance reassessment ☐ Appendix D returned to school Parent/Guardian: Signature: _____ Date:_____ Comments: _____
	RTPA - Stage 6 Unrestricted return to contact sports. **Activities permitted:** ✓ Full participation in contact sports, games/competition
	School ☐ Student has completed full participation in contact sports. ☐ Appendix D sent home to parent/guardian School Initial (for example, collaborative team lead/designate): _____ Date: _____
	Home ☐ Student has not exhibited or reported a return of symptoms or new symptoms and can progress to RTPA Plan. ☐ Student has exhibited/reported a return of symptoms or new symptoms and must return to medical doctor/nurse practitioner for Medical Clearance reassessment ☐ Appendix D returned to school for documentation purposes. Parent/Guardian: Signature: _____ Date:_____ Comments: _____

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Appendix E
Documentation for Medical Clearance

Form is to be provided to students who have completed the Return to School (RTS) Stage 4b and Return to Physical Activity (RTPA) Stage 4 (consult the School Concussion Management Plan). Student must be medically cleared by a medical doctor/nurse practitioner prior to moving on to full participation in non-contact physical activities and full contact practices (RTPA Stage 5).

Student name: _____
Date: _____

I have examined this student and confirm they are medically cleared to participate in the following activities:

- Full participation in Physical Education classes
- Full participation in Intramural physical activities (non-contact)
- Full participation in non-contact Interschool Sports (practices and competition)
- Full-contact training/practice in contact Interschool Sports

Other comments:

_____
_____
_____

Medical Doctor/Nurse Practitioner

In rural or northern regions, the Medical Clearance Letter may be completed by a nurse with pre-arranged access to a medical doctor or nurse practitioner. Forms completed by other licensed healthcare professionals should not be otherwise accepted.

Name: _____

Signature: _____

Date: _____

What if symptoms recur? A student who has received Medical Clearance and has a recurrence of symptoms or new symptoms appear, must immediately remove themselves from play, inform their parent/guardian/teacher/coach, and return to the medical doctor or nurse practitioner for Medical Clearance reassessment before returning to physical activity.

Table 1: School Concussion Management Plan

Return to School (RTS) Stages	**Return to Physical Activity (RTPA) Stages**
Each stage must last a minimum of 24 hours.	
RTS – Stage 3a Student begins with an initial time at school of 2 hours.	**RTPA – Stage 3** Simple locomotor activities and sport-specific exercise to add movement.

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The individual RTS Plan is developed by the Collaborative Team following the student conference and appraisal of the student's individual needs, determining possible modifications/adaptations for student learning. (consult Table 5 in APG).	
RTS - Stage 3b Student continues attending school half time with gradual increase in school attendance time, increased school work, and decrease in adaptation of learning strategies and/or approaches.	
RTS – Stage 4a Full day school, minimal adaptation of learning strategies and/or approaches. Nearly normal workload.	**RTPA – Stage 4** Progressively increase physical activity. Non-contact training drills to add coordination and increased thinking.
RTS – Stage 4b At school: full day, without adaptation of learning strategies and/or approaches.	**Before continuing on to RTPA Stages 5, the student must:** ☐ have completed RTS Stage 4a and 4b (full day at school without adaptions of learning strategies and/or approaches), ☐ have completed RTPA Stage 4 and be symptom-free; and ☐ obtain signed Medical Clearance from a medical doctor or nurse practitioner.
	RTPA – Stage 5 Following Medical Clearance, full participation in all non-contact physical activities (i.e., non-intentional body contact) and full contact training/practice in contact sports
	RTPA - Stage 6 Unrestricted return to contact sports.

The RTS and RTPA Plan has been developed in partnership with Parachute and is based on the most recent research and recommendations of the expert scientific community on concussion i.e., the Canadian Guidelines on Concussion in Sport, July 2017 and the Berlin Consensus Statement on Concussion in Sport, October 2016.

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Appendix F
Concussion Prevention Strategies

PPM 158 (Policy/Program Memorandum #158: School Board Policies on Concussion) recognizes the importance of prevention and states that every school board policy should include strategies for preventing and minimizing the risk of sustaining concussions (and other head injuries) in schools and at off-site school events.

The prevention strategies are organized into the following four sections:

- Teachers/coaches/supervisors
- Students/athletes
- School boards, athletic associations and referee associations
- Parents/guardians

Prior to the sport season/beginning of the school year teachers/coaches/supervisors should:

- be knowledgeable of school board's concussion policy and procedures for prevention, identification, and management (return to learn and return to physical activity);
- be knowledgeable about safe practices in the sport/activity (for example, the rules and regulations and the specific sport/activity pages in the Ontario Physical Education Safety Guidelines);
- be familiar with the risks of a concussion or other potential injuries associated with the activity/sport and how to minimize those risks;
- be up to date and enforce school board/athletic association/referee rule changes associated with minimizing the risks of concussion;
- be up to date with current body contact skills and techniques (for example, safe tackling in tackle football), when coaching/supervising contact activities;
- be knowledgeable (when applicable) with the requirements for wearing helmets. (To date there is no evidence that helmets protect against concussions.) For more information on helmets consult the Fundamentals of Safety;
- determine that protective equipment is approved by a recognized equipment standards association (for example, Canadian Safety Standards, National Operating Committee on Standards for Athletic Equipment), is well maintained, and is visually inspected prior to activity; and
- determine (where applicable) that protective equipment is inspected within approved timelines, by a certified re-conditioner as required by manufacturer (for example, football helmet).

During the physical activity unit/sport season/intramural activity teachers/coaches/supervisors should:

- teach skills and techniques in the proper progression;
- provide activity/sport-specific concussion information when possible;
- teach and enforce the rules and regulations of the sport/activity during practices and games/competition (particularly those that limit or eliminate body contact, or equipment on body contact);
- reinforce the principles of head-injury prevention (for example, keeping the head up and avoiding collision);
- teach students/athletes involved in body contact activities about:
    - sport-specific rules and regulations of body contact (for example, no hits to the head); and
    - body contact skills and techniques and require the successful demonstration of these skills in practice prior to competition.
- discourage others from pressuring injured students/athletes to play/participate;

- demonstrate and role model the ethical values of fair play and respect for opponents;
- encourage students/athletes to follow the rules of play, and to practice fair play;
- use game/match officials in higher-risk interschool sports that are knowledgeable, certified and/or experienced in officiating the sport; and
- inform students about the importance using protective equipment (for example, helmets, padding, guards) that is properly fitted (as per manufacturer's guidelines) and properly worn.
- Prior to the sport season/intramural activity/beginning of the school year students/athletes should be informed about:
- Concussions
    - definition
    - seriousness of concussions
    - causes
    - signs and symptoms
    - the school board's Identification and management procedure
- the risks of a concussion associated with the activity/sport and how to minimize those risks including sport-specific prevention strategies;
- the importance of respecting the rules of the game and practising Fair Play (for example, to follow the rules and ethics of play, to practice good sportsmanship at all times and to respect their opponents and officials);
- the dangers of participating in an activity while experiencing the signs and symptoms of a concussion and potential long-term consequences;
- the importance of:
    - immediately informing the teacher/coach/supervisor of any signs or
    - symptoms of a concussion, and removing themselves from the activity;
    - encouraging a teammate with signs or symptoms to remove themselves from the activity and to inform the teacher/coach/supervisor;
    - informing the teacher/coach/supervisor when a classmate/teammate has signs or symptoms of a concussion; and
    - determining that, when students/athletes are permitted to bring their own protective equipment, it is properly fitted (as per manufacturers guidelines), properly worn, in good working order and suitable for personal use.
- the use of helmet when they are required for a sport/activity.
    - Helmets do not prevent concussions. They are designed to protect against skull fractures, major brain injuries (including bleeding into or around the brain), brain contusions and lacerations.
    - Helmets are to be properly fitted (as per manufacturer's guidelines) and properly worn (for example, only one finger should fit between the strap and the chin when strap is done up).
- May use a sample Concussion Lesson (Appendix G) or create their own.

During the physical activity unit/sport season/intramural activity students/athletes should be informed about:

- attending safety clinics/information sessions on concussions for the activity/sport;
- be familiar with the seriousness of concussion and the signs and symptoms of concussion;
- demonstrating safe contact skills during controlled practice sessions prior to competition;
- demonstrating respect for the mutual safety of fellow athletes (for example, no hits to the head, follow the rules and regulations of the activity);
- wearing properly fitted protective equipment;
- reporting any sign or symptom of a concussion immediately to
- teacher/coach/supervisor from a hit, fall or collision; and

- encouraging team mates/fellow students to report sign(s) or symptom(s) of a concussion and to refrain from pressuring injured students/athletes to play.

Sample strategies/tools to educate students/athletes about concussion prevention information:

- Hold a pre-season/-activity group/team meeting on concussion education.
- Develop and distribute an information checklist for students/athletes about prevention strategies.
- Post concussion information to inform/reinforce symptoms and signs and what to do if a concussion is suspected.
- Post information posters on prevention of concussions (for example, encouraging students to report concussion symptoms) in high traffic student areas (for example, change room/locker area/classroom/gymnasium).
- Implement concussion classroom learning modules aligned with the curriculum expectations.
- Distribute concussion fact sheets (prevention, signs and symptoms) for each student/athlete on school teams.
- Distribute and collect completed student concussion contract or pledge (signed by student/athlete and parents/guardians).

Students/athletes who are absent for safety lessons (for example, information, skills, techniques) must be provided with the information and training prior to the next activity sessions.

Prior to the sport season/beginning of the school year school boards, athletic associations and referee associations should:

- consider rule changes to the activity, to reduce the head injury incidence or severity, where a clear-cut mechanism is implicated in a particular sport; and
- consider rule enforcement to minimize the risk of head injuries.

Prior to the sport season/intramural activity/beginning of the school year parents/guardians to be informed of the:

- risks and possible mitigations of the activity/sport;
- dangers of participating with a concussion;
- signs and symptoms of a concussion;
- school board's identification, diagnosis and management procedures;
- sport-specific concussion prevention strategies;
- importance of encouraging the ethical values of fair play and respect for opponents; and
- importance of determining that, when students/athletes are permitted to bring their own protective equipment, it is properly fitted (as per manufacturers guidelines), properly worn, in good working order and suitable for personal use.

RESOURCES

Ontario portal: www.Ontario.ca/concussions

SUDBURY CATHOLIC DISTRICT SCHOOL BOARD

Appendix G
Sample Concussion Lesson

Concussion Lesson	
Brainstorm with class Answer to the question	**Can anyone tell me what a concussion is?** Brain storm ideas A concussion: • is a brain injury that causes changes in how the brain functions, leading to symptoms that can be physical (e.g., headache, dizziness), cognitive (e.g., difficulty concentrating or remembering), emotional/behavioural (e.g., depression, irritability), and/or related to sleep (e.g., drowsiness, difficulty falling asleep); • may be caused either by a direct blow to the head, face or neck, or by a hit to the body that transmits such force to the head that it causes the brain to move rapidly within the skull; • often occur without a reported loss of consciousness; • cannot normally be seen on X-rays, or standard CT and MRI scans. Signs and symptoms of a suspected concussion can be identified by a designated and specifically-trained first responder. It is important for your immediate and long-term health to self-report any signs or symptoms of a concussion to your teacher/coach/trainer/parents. It is also important for you to report any signs or symptoms of a concussion that you observe from a friend/teammate to your teacher/coach/trainer/parents. Your friend/teammate may not be in a position to recognize the signs and symptoms at the time. Due to the complexity of this serious brain injury, a consult with a medical concussion specialist (e.g., neurosurgeon, neurologist, primary care sports medicine doctor with added qualification) should be sought whenever possible. The minimum standard for the diagnosis of a concussion is from a medical doctor or nurse practitioner, who would follow-up with informed medical management.
Discussion with class	**Do you know anyone who has had a concussion?** Most will be athletes (ex Sydney Crosby) **Eric Lindros:** Lindros is the hockey name most synonymous with concussions, but there are dozens of NHL players who've similarly suffered from head trauma. Lindros deserves immense credit for lasting 15 seasons despite more than 10 known concussions, but it ended — somewhat early, and due to the cumulative affect of his head injuries, in 2007 at age 34. **Brett Lindros:** Eric's younger brother, Brett, was drafted in the first round by the New York Islanders in 1994, but suffered three concussions in just two seasons and was forced to retire in 1996; the younger Lindros was told at the time to never put on another pair of skates — he played just 51 games for the Isles, scoring two goals.

	Steve Young: Successfully filled some massive shoes, taking over as the San Francisco 49ers' quarterback after Joe Montana's era. But three weeks into the 1999 season, he called it quits after suffering what was believed to be the eighth known concussion of his career. **Scott Stevens:** One of the most physically dominating D-men of all time, Stevens was known for, among other things, a devastating, concussion-inducing hit on Lindros in 2001. He suffered numerous head traumas himself, and was forced out of the 2003-04 season after being diagnosed with post-concussion syndrome. **Keith Primeau:** A 15-year veteran of the NHL and one of the leading forwards of his era, Primeau took the final of numerous concussions in his career and retired nine games into the 2005-06 season. He's since become a leading proponent of the fight against head injuries in hockey. **Pat LaFontaine:** Had a 15-year Hall of Fame career, but doctors with the Sabres recommended he retire after a hit to the head from Penguins' enforcer Francois Leroux in 1997. LaFontaine believed he could still play, and was traded to the Rangers where he led the team in scoring and notched his 1,000th career point. He accidently collided with teammate Mike Keane during a 1999 practice and suffered what would be his final concussion — he retired shortly after the incident. **Nick Kypreos:** Now a popular and scoop-breaking analyst for Sportsnet, Kypreos played for over a decade in the NHL, but was forced to retire shortly after a fight in which he fell and struck his unprotected head on the ice. **Amanda Kessel:** The sister of former Leaf Phil Kessel, Amanda never recovered enough to continue a starring role with the University of Wisconsin; she missed all her last season and announced that August that she wouldn't return to the ice this season as well. **Kevin Kolb:** Signed a two year, $13-million deal in March 2013 to quarterback the Buffalo Bills, but suffered a severe concussion in a pre-season game in Washington in August of that year. He was placed on injured reserve, then retired in March 2014 due to the lingering effects of three concussions. **Taylor Twellman:** Youngest player in the MLS to reach 100 goals, doing so at age 29 in 2009. The former New England Revolution star retired in 2010 after being unable to find playing time due in large part to previous head trauma.
Play video (choice depends on age of students)	**It is important to recognize the signs of a concussion and also know that every school in Ontario has rules that we must follow.** https://youtu.be/_5hIm3FRFYU Best video Grade 4+ https://youtu.be/zCCD52Pty4A Older students Gr 7+ https://youtu.be/yyRBlSAfb_k
	What does this mean in our school?

Speaking Notes	We have a concussion protocol that all school boards in Ontario follow. These are the rules all schools, teachers, students, coaches and parents have to follow if a student is suspected of having a concussion. As a student, you have an important role. You have to tell us all what's going on. How you feel. A concussion is serious and schools will ask you and your parents to see a doctor to help us understand what is going on. What is most important to us is to have you back in the classroom where you can learn. If you are part of a school team that will happen after. It is very important that if you get hurt outside of school that you or your parents let the school know so that a plan can be made to help you in school.
Concussion Information	If you join a team you and your family will be asked to sign an acknowledgement of concussion information Appendix I.
Further Information There are scripts to help facilitate these modules (found under the module link)	For more learning: Concussions e-Modules for Students http://sportconcussionlibrary.com/halton-student-concussion-education-program-hscep/ It is highly recommended that students work through the modules Grade 3+
To help teachers better understand concussions	If teachers would like to better understand concussions and the protocol all schools must follow you can register for OPHEA's free Concussion course http://elearning.ophea.net/course/view.php?id=5
To help coaches better understand concussions	Coaches may want to take the online Module at http://www.coach.ca/-p153487
Teachers should feel free to revise the lesson to best suit their students' need. What is important is that all students understand the seriousness of concussions.	

SUDBURY CATHOLIC DISTRICT SCHOOL BOARD

Appendix H
Return to School Support Strategies

COGNITIVE DIFFICULTIES		
Post Concussion Symptoms	**Impact on Student's Learning**	**Potential Strategies and/or Approaches**
Headache and Fatigue	Difficulty concentrating, paying attention or multitasking	• ensure instructions are clear (e.g., simplify directions, have the student repeat directions back to the teacher) • allow the student to have frequent breaks, or return to school gradually (e.g., 1-2 hours, half-days, late starts) • keep distractions to a minimum (e.g., move the student away from bright lights or noisy areas) • limit materials on the student's desk or in their work area to avoid distractions • provide alternative assessment opportunities (e.g., give tests orally, allow the student to dictate responses to tests or assignments, provide access to technology)
Difficulty remembering or processing speed	Difficulty retaining new information, remembering instructions, accessing learned information	• provide a daily organizer and prioritize tasks • provide visual aids/cues and/or advance organizers (e.g., visual cueing, non-verbal signs) • divide larger assignments/assessments into smaller tasks • provide the student with a copy of class notes • provide access to technology • repeat instructions • provide alternative methods for the student to demonstrate mastery
Difficulty paying attention/ concentrating	Limited/short-term focus on schoolwork Difficulty maintaining a regular academic workload or keeping pace with work demands	• coordinate assignments and projects among all teachers • use a planner/organizer to manage and record daily/weekly homework and assignments • reduce and/or prioritize homework, assignments and projects • extend deadlines or break down tasks • facilitate the use of a peer note taker • provide alternate assignments and/or tests • check frequently for comprehension • consider limiting tests to one per day and student may need extra time or a quiet environment

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EMOTIONAL/BEHAVIOURAL DIFFICULTIES		
Post Concussion Symptoms	**Impact on Student's Learning**	**Potential Strategies and/or Approaches**
Anxiety	Decreased attention/concentration Overexertion to avoid falling behind	• Inform the student of any changes in the daily timetable/schedule • adjust the student's timetable/schedule as needed to avoid fatigue (e.g., 1-2 hours/periods, half-days, full-days) • build in more frequent breaks during the school day • provide the student with preparation time to respond to questions
Irritable or Frustrated	Inappropriate or impulsive behaviour during class	• encourage teachers to use consistent strategies and approaches • acknowledge and empathize with the student's frustration, anger or emotional outburst if and as they occur • reinforce positive behaviour • provide structure and consistency on a daily basis • prepare the student for change and transitions • set reasonable expectations • anticipate and remove the student from a problem situation (without characterizing it as punishment)
Light/Noise Sensitivity	Difficulties working in classroom environment (e.g., lights, noise, etc.)	• arrange strategic seating (e.g., move the student away from window or talkative peers, proximity to the teacher or peer support, quiet setting) • where possible provide access to special lighting (e.g., task lighting, darker room) • minimize background noise • provide alternative settings (e.g., alternative work space, study carrel) • avoid noisy crowded environments such as assemblies and hallways during high traffic times • allow the student to eat lunch in a quiet area with a few friends • where possible provide ear plugs/headphones, sunglasses
Depression/ Withdrawal	Withdrawal from participation in school activities or friends	• build time into class/school day for socialization with peers • partner student with a "buddy" for assignments or activities

SUDBURY CATHOLIC DISTRICT SCHOOL BOARD

Appendix I
Concussion Education

WHAT IS A CONCUSSION?
A concussion is a brain injury that can't be seen on X-rays, CT or MRI scans. It affects the way a person thinks and can cause a variety of symptoms.

WHAT CAUSES A CONCUSSION?
Any blow to the head, face or neck, or somewhere else on the body that causes a sudden jarring of the head may cause a concussion. Examples include getting body-checked in hockey or falling and hitting your head on the floor.

WHEN SHOULD I SUSPECT A CONCUSSION?
A concussion should be suspected in anyone who sustains a significant impact to the head, face, neck, or body and reports ANY symptoms or demonstrates ANY visual signs of a concussion. A concussion should also be suspected if a person reports ANY concussion symptoms to one of their peers, teacher, parent, coach, or other responsible adult, or if anyone witnesses a person exhibiting ANY of the visual signs of concussion. Some people will develop symptoms immediately while others will develop delayed symptoms (beginning 24-48 hours after the injury).

WHAT ARE THE SYMPTOMS OF A CONCUSSION?
A person does not need to be knocked out (lose consciousness) to have had a concussion. Common symptoms include:

- *Headaches or head pressure*
- *Dizziness*
- *Nausea and vomiting*
- *Blurred or fuzzy vision*
- *Sensitivity to light or sound*
- *Balance problems*
- *Feeling tired or having no energy*
- *Not thinking clearly*
- *Feeling slowed down*

WHAT ARE THE VISUAL SIGNS OF A CONCUSSION?
Visual signs of a concussion may include:

- *Lying motionless on the floor*
- *Slow to get up after a direct or indirect hit to the head*
- *Disorientation or confusion or inability to respond appropriately to questions*

WHAT SHOULD I DO IF I SUSPECT A CONCUSSION?

- *Easily upset or angered*
- *Sadness*
- *Nervousness or anxiety*
- *Feeling more emotional*
- *Sleeping more or sleeping less*
- *Having a hard time falling asleep*
- *Difficulty working on a computer*
- *Difficulty reading*
- *Difficulty learning new information*
- *Blank or vacant stare*
- *Balance, gait difficulties, motor incoordination, stumbling, slow labored movements*
- *Facial injury after head trauma*
- *Clutching head*

If a student is suspected of sustaining a concussion, they are immediately removed from activity. Any student who is suspected of having sustained a concussion during sport or physical activities must not be allowed to return to the same game or practice.
It is important that ALL students with a suspected concussion undergo medical assessment by a medical doctor or nurse practitioner, as soon as possible. ALL students with a diagnosed concussion should receive written medical clearance from a medical doctor or nurse practitioner before returning to sport activities.

SUDBURY CATHOLIC DISTRICT SCHOOL BOARD

WHEN CAN THE STUDENT RETURN TO SCHOOL AND SPORTS?

It is important that students diagnosed with a concussion follow a step-wise return to school and sports-related activities that includes the following Return-to-School and Return-to-Sport Strategies. It is important that students return to full-time school activities before progressing to stage 5 and 6 of the Return-to-Sport Strategy.

Return-to-School Strategy

Stage	Aim	Activity	Goal of each step
1	Daily activities at home that do not give the student-athlete symptoms	Typical activities during the day as long as they do not increase symptoms (i.e. reading, texting, screen time). Start at 5- 15 minutes at a time and gradually build up.	Gradual return to typical activities.
2	School activities	Homework, reading or other cognitive activities outside of the classroom.	Increase tolerance to cognitive work.
3	Return to school part-time	Gradual introduction of schoolwork. May need to start with a partial school day or with increased breaks during the day.	Increase academic activities.
4	Return to school full-time	Gradually progress.	Return to full academic activities and catch up on missed school work.

Return-to-Sport Strategy

Stage	Aim	Activity	Goal of each step
1	Symptom- limiting activity	Daily activities that do not provoke symptoms.	Gradual re-introduction of work/school activities.
2	Light aerobic activity	Walking or stationary cycling at slow to medium pace. No resistance training.	Increase heart rate.
3	Sport-specific exercise	Running or skating drills. No head impact activities.	Add movement.
4	Non-contact training drills	Harder training drills, e.g. passing drills. May start progressive resistance training.	Exercise, coordination and increased thinking.
5	Full contact practice	Following medical clearance and complete return to school.	Restore confidence and assess functional skills by coaching staff.
6	Return to sport	Normal game play.	

HOW CAN I HELP PREVENT CONCUSSIONS AND THEIR CONSEQUENCES?

Concussion prevention, recognition and management require everyone to follow the rules and regulations when participating in sport, respect others, avoid head contact, and report suspected concussions.

TO LEARN MORE ABOUT CONCUSSIONS PLEASE VISIT: Parachute: **www.parachutecanada.org/concussion**

_____ _____

Printed name of student Printed name of parent/guardian

_____ _____

Signature of Student Date Signature of parent/guardian Date

Concussion guide for

PARENTS AND CAREGIVERS

Parachute
Concussion Series

What is a concussion?

A concussion is a brain injury that cannot be seen on routine X-rays, CT scans, or MRIs. It affects the way a child may think and remember things, and can cause a variety of symptoms.

What are the signs and symptoms of a concussion?

Your child does not need to be knocked out (lose consciousness) to have had a concussion. Your child might experience one or more of the following:

Thinking Problems	Child's Complaints	Other Problems
• Does not know time, date, place, details about a recent activity • General confusion • Cannot remember things that happened before and after the injury • Knocked out	• Headache • Dizziness • Feels dazed • Feels "dinged" or stunned; "having my bell rung" • Sees stars, flashing lights • Ringing in the ears • Sleepiness • Loss of vision • Sees double or blurry • Stomachache, stomach pain, nausea	• Poor co-ordination or balance • Blank stare/glassy-eyed • Vomiting • Slurred speech • Slow to answer questions or follow directions • Easily distracted • Poor concentration • Strange or inappropriate emotions (i.e., laughing, crying, getting mad easily) • Not participating well

It is harder for infants, toddlers, and preschoolers to communicate how they are feeling. If you have a young child, you might notice any of the following: crying more than usual; unsteady walking; lack of interest in favourite toys; changes in nursing, eating or sleeping patterns; or loss of new skills, such as toilet training.

Get medical help immediately if your child has any "red flag" symptoms such as neck pain, repeated vomiting, growing confusion, seizures, and weakness or tingling in their arms or legs. These may be signs of a more serious injury.

What causes a concussion?

Any blow to the head, face or neck, or a blow to the body which causes a sudden jarring of the head may cause a concussion (e.g., a ball to the head, colliding with another person).

What should I do if I suspect my child has a concussion?

In all suspected cases of concussion, your child should stop the activity right away. Continuing increases their risk of more severe, longer-lasting concussion symptoms, as well as increases their risk of other injury.

The Concussion Recognition Tool 5 (CRT5) can be used by anyone to help recognize the signs and symptoms of a possible concussion.

Your child should not be left alone and should be seen by a doctor as soon as possible that day.

If your child loses consciousness, call an ambulance to take them to the hospital right away. Do not move your child or remove any equipment such as a helmet.

Your child should not return to play the same day.

How long before my child gets better?

The signs and symptoms of a concussion often last for one to four weeks but may last longer. In some cases, children may take many weeks or months to heal. If your child has had a concussion before, they may take longer to heal.

If your child's symptoms are persistent (i.e., last longer than four weeks in youth under 18 years old), they should be referred to a healthcare professional who is an expert in the management of concussion.

How is concussion treated?

After an initial short period of rest (24 to 48 hours), light cognitive and physical activity can begin, as long as these don't worsen symptoms. A medical doctor, preferably one with experience managing concussions, should be consulted before beginning step-wise Return-to-School and Return-to-Sport Strategies.

As your child is recovering from concussion, they should not do any activities that may make their symptoms worse. This might mean limiting activities such as riding their bike, play wrestling, reading, working on the computer or playing video games.

Recovering from concussion is a process that takes patience. If your child goes back to activities before they are ready, it is likely to make their symptoms worse, and their recovery might take longer.

When should my child go to the doctor?

Anyone with a possible head injury should be seen by a doctor as soon as possible. If your child is diagnosed with a concussion, the doctor should schedule a follow-up visit within the next one to two weeks.

Take your child back to the doctor immediately if, after being told they have a concussion, they have worsening symptoms, such as:

- being more confused
- headache that is getting worse
- vomiting more than twice
- not waking up
- having any trouble walking
- having a seizure
- strange behaviour

When can my child return to school?

Your child may find it hard to concentrate in class, may get a worse headache, or feel sick to their

stomach. Your child should stay home from school if being in class makes their symptoms worse. Once they feel better, they can try going back to school part time to start (i.e., for half days) and if they are OK with that, then they can go back full time.

On average, children with concussion miss one to four days of school. Each concussion is unique, so your child may progress at a different rate than others.

The Return-to-School Strategy provides information on the stages of returning to the classroom. Return to school must come before full return to sport.

When can my child return to sport and physical activity?

It is very important that your child does not go back to full participation in sport if they have any concussion signs or symptoms. Return to sport and physical activity must follow a step-wise approach.

In this approach:

- Each stage is at least 24 hours.
- Your child moves on to the next stage when they can tolerate activities without new or worsening symptoms.
- If any of your child's symptoms worsen, they should stop and go back to the previous stage for at least 24 hours.

Stage 1: After an initial 24 to 48 hours of rest, light cognitive and physical activity can begin, as long as these don't worsen symptoms. Your child can start with daily activities such as moving around the home and simple chores, such as making their bed.

Stage 2: Light aerobic activity such as walking or stationary cycling, for 10 to 15 minutes. Your child shouldn't do any heavy lifting or resistance training (e.g., bodyweight exercises, weight training).

Stage 3: Individual physical activity with no risk of contact for 20 to 30 minutes. Your child can participate in simple, individual activities, such as going for a walk at recess or shooting a basketball. Your child shouldn't do any resistance training.

Stage 4: Begin practising with no contact (no checking, no heading the ball, etc.). Add in longer and more challenging physical activity. Start to add in resistance training (if appropriate for your child).

Get clearance from a doctor before moving on to Stages 5 and 6.

Stage 5: Participate in full practice with contact, if your child plays a contact sport.

Stage 6: Full game play or competition.

The Return-to-Sport Strategy provides more information on the stages of returning to sport.

Your child should not return to sport until cleared by a doctor!

Returning too soon before full recovery from concussion puts your child at higher risk of sustaining another concussion, with symptoms that may be more severe and last longer.

Additional Resources

Return-to-School Strategy
http://horizon.parachutecanada.org/en/article/parachutes-return-to-learn-protocol

Return-to-Sport Strategy
http://horizon.parachutecanada.org/wp-content/uploads/2017/06/Concussion-ReturnToSport.pdf

Canadian Guideline on Concussion in Sport
http://www.parachutecanada.org/guideline

Concussion: Baseline Testing
http://www.parachutecanada.org/downloads/injurytopics/BaselineTesting-FactSheet-Parachute.pdf

Parachute
Concussion Series

Strategy for RETURN TO SCHOOL after a Concussion

1. **Each stage is at least 24 hours. Move to the next stage only when activities are tolerated without new or worsening symptoms.**
2. **If symptoms re-appear, return to the previous stage for at least 24 hours.**
3. **If symptoms don't improve, but continue to get worse, contact your doctor or get medical help immediately.**

AT HOME

Cognitive & physical rest (24-48 hours)

OK if tolerated
- ✔ Short board games
- ✔ Short phone calls
- ✔ Camera photography
- ✔ Crafts

Not OK
- ✘ School
- ✘ Physical exertion/ stair climbing
- ✘ Organized sports

If tolerated, limited amounts of
- TV
- Computer/cell phone use
- Reading

READY FOR NEXT STAGE? Symptoms start to improve OR after resting for 48 hours max.

Stage 1 — Light cognitive activity

OK if tolerated
- ✔ Easy reading
- ✔ Limited TV
- ✔ Drawing/LEGO/ board games
- ✔ Some peer contact

Not OK
- ✘ School
- ✘ Work
- ✘ Physical exertion/ stair climbing
- ✘ Organized sports

If tolerated, limited amounts of
- Computer/cell phone use

READY FOR NEXT STAGE? Tolerate 30 mins. of cognitive activity at home

Stage 2 — School-type work/ Light physical activity

OK if tolerated
- ✔ School-type work in 30 min. chunks
- ✔ Light physical activity
- ✔ Some peer contact

Not OK
- ✘ School attendance
- ✘ Work
- ✘ Physical exertion/ stair climbing
- ✘ Organized sports

READY FOR NEXT STAGE? Tolerate up to 60 mins. of cognitive activity in 2-3 chunks

AT SCHOOL

Stage 3a — Part-time school Light load

OK if tolerated
- ✔ Up to 120 mins. of cognitive activity in chunks
- ✔ Half-days at school, 1-2 times a week
- ✔ Some light physical activity

Not OK
- ✘ Music/Phys. Ed class
- ✘ Tests/exams
- ✘ Homework
- ✘ Heavy physical loads (e.g. backpack)
- ✘ Organized sports

READY FOR NEXT STAGE? Tolerate school work up to 120 mins. a day for 1-2 days/week

Stage 3b — Part-time school Moderate load

OK if tolerated
- ✔ Limited testing
- ✔ School work for 4-5 hours/day in chunks
- ✔ Homework up to 30 mins./day
- ✔ 3-5 days of school/week
- ✔ Decrease learning accommodations

Not OK
- ✘ Phys. Ed class/ physical exertion
- ✘ Standardized tests/exams
- ✘ Organized sports

READY FOR NEXT STAGE? Tolerate school work 4-5 hours/ day in chunks for 2-4 days/week

Stage 4a — Nearly normal workload

OK if tolerated
- ✔ Nearly normal cognitive activities
- ✔ Routine school work as tolerated
- ✔ Homework up to 60 mins./day
- ✔ Minimal learning accommodations

Not OK
- ✘ Phys. Ed class
- ✘ Standardized tests/exams
- ✘ Full participation in organized sports

READY FOR NEXT STAGE? Tolerate full-time academic load without worsening symptoms

Stage 4b — Full time

OK if tolerated
- ✔ Normal cognitive activities
- ✔ Routine school work
- ✔ Full curriculum load
- ✔ No learning accommodations

Not OK
- ✘ Full participation in sports until medically cleared. (See Return-to-Sport Strategy)

READY FOR NEXT STAGE? Stages 5-6 of the *Return-to-Sport Strategy*

Adapted from: Parachute's Canadian Guideline on Concussion in Sport (2017) • Consensus Statement on Concussion in Sport (McCrory et al., 2017) • CATT Return To School • McMasterU's CanChild Return to School Guideline • Ophea's Ontario Physical Education Safety Guidelines

Concussion guide for

TEACHERS

Parachute
Concussion Series

What is a concussion?

A concussion is a brain injury that cannot be seen on routine X-rays, CT scans, or MRIs. It affects the way a student may think and remember things, and can cause a variety of symptoms.

What are the signs and symptoms of a concussion?

A student does not need to be knocked out (lose consciousness) to have had a concussion. The student might experience one or more of the following:

Thinking Problems	Student's Complaints	Other Problems
• Does not know time, date, place, details about a recent activity • General confusion • Cannot remember things that happened before and after the injury • Knocked out	• Headache • Dizziness • Feels dazed • Feels "dinged" or stunned; "having my bell rung" • Sees stars, flashing lights • Ringing in the ears • Sleepiness • Loss of vision • Sees double or blurry • Stomachache, stomach pain, nausea	• Poor co-ordination or balance • Blank stare/glassy-eyed • Vomiting • Slurred speech • Slow to answer questions or follow directions • Easily distracted • Poor concentration • Strange or inappropriate emotions (i.e., laughing, crying, getting mad easily) • Not participating well

Get medical help immediately if a student has any "red flag" symptoms such as neck pain, repeated vomiting, growing confusion, seizures, and weakness or tingling in their arms or legs. These may be signs of a more serious injury.

What causes a concussion?

Any blow to the head, face or neck, or a blow to the body which causes a sudden jarring of the head may cause a concussion (e.g., a ball to the head, colliding with another person).

What should I do if I suspect a student has a concussion?

In all suspected cases of concussion, the student should stop the activity right away. Continuing increases their risk of more severe, longer-lasting concussion symptoms, as well as increases their risk of other injury.

The Concussion Recognition Tool 5 (CRT5) can be used by anyone to help recognize the signs and symptoms of a possible concussion.

The student should not be left alone and should be seen by a doctor as soon as possible that day. They should not drive.

If the student loses consciousness, call an ambulance to take them to the hospital right away. Do not move them or remove any equipment such as a helmet.

The student should not return to play the same day.

How long will it take for the student to get better?

The signs and symptoms of a concussion often last for one to four weeks but may last longer. In some cases, students may take many weeks or months to heal. If the student has had a concussion before, they may take longer to heal.

If the student's symptoms are persistent (i.e., last longer than four weeks in youth under 18 years old or last longer than two weeks in students aged 18 or older), they should be referred to a healthcare professional who is an expert in the management of concussion.

How is concussion treated?

After an initial short period of rest (24 to 48 hours), light cognitive and physical activity can begin, as long as these don't worsen symptoms.

As the student is recovering from concussion, they should not do any activities that may make their symptoms worse. This might mean limiting activities such as exercising, driving, and screen time on their phone or other devices. If mental activities (e.g., reading, using the computer) worsen the student's symptoms, they might have to stay home from school.

Recovering from concussion is a process that takes patience. If the student goes back to activities before they are ready, it is likely to make their symptoms worse, and their recovery might take longer.

When should the student go to the doctor?

Anyone with a possible head injury should be seen by a doctor as soon as possible.

The student should go back to the doctor immediately if, after being told they have a concussion, they have worsening symptoms, such as:

- being more confused
- headache that is getting worse
- vomiting more than twice
- not waking up
- having any trouble walking
- having a seizure
- strange behaviour

When can the student return to school?

The student may find it hard to concentrate in class, may get a worse headache, or feel sick to their stomach. They should stay home from school if being in class makes their symptoms worse. Once they feel better, they can try going back to school part time to start (i.e., for half days) and if they are OK with that, then they can go back full time.

On average, students with concussion miss one to four days of school. Each concussion is unique, so the student may progress at a different rate than others.

The Return-to-School Strategy provides information on the stages of returning to the classroom. Return to school must come before full return to sport.

When can the student return to sport and physical activity?

It is very important that the student does not go back to full participation in sport if they have any concussion signs or symptoms. Return to sport and physical activity must follow a step-wise approach.

In this approach:

- Each stage is at least 24 hours.
- The student moves on to the next stage when they can tolerate activities without new or worsening symptoms.
- If any of the student's symptoms worsen, they should stop and go back to the previous stage for at least 24 hours.

Stage 1: After an initial 24 to 48 hours of rest, light cognitive and physical activity can begin, as long as these don't worsen symptoms. The student can start with daily activities like moving around the home and simple chores, such as making their bed.

Stage 2: Light aerobic activity such as walking or stationary cycling, for 10 to 15 minutes. The student shouldn't do any heavy lifting or resistance training (e.g., bodyweight exercises, weight training).

Stage 3: Individual physical activity with no risk of contact for 20 to 30 minutes. The student can participate in simple, individual activities, such as going for a walk at recess or shooting a basketball. The student shouldn't do any resistance training.

Stage 4: Begin practising with no contact (no checking, no heading the ball, etc.). Add in longer and more challenging physical activity. Start to add in resistance training (if appropriate for the student).

Get clearance from a doctor before moving on to Stages 5 and 6.

Stage 5: Participate in practice with contact, if the student plays a contact sport.

Stage 6: Full game play or competition.

The Return-to-Sport Strategy provides more information on the stages of returning to sport.

The student should never return to sport until cleared by a doctor!

Returning before full recovery from concussion puts the student at higher risk of sustaining another concussion, with symptoms that may be more severe and last longer.

Additional Resources

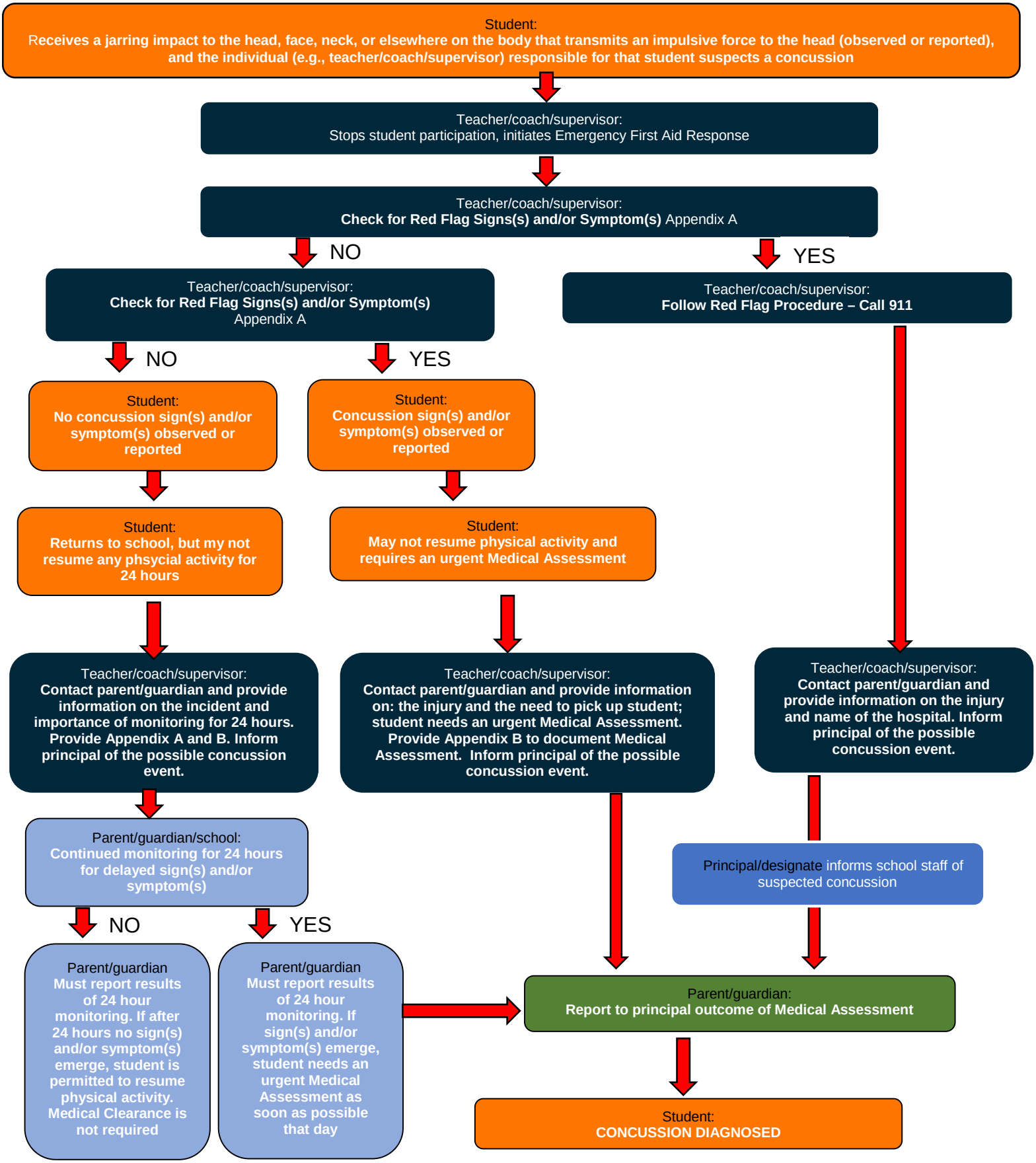
Return-to-School Strategy
http://horizon.parachutecanada.org/en/article/parachutes-return-to-learn-protocol

Return-to-Sport Strategy
http://horizon.parachutecanada.org/wp-content/uploads/2017/06/Concussion-ReturnToSport.pdf

Canadian Guideline on Concussion in Sport
http://www.parachutecanada.org/guideline

SUDBURY CATHOLIC DISTRICT SCHOOL BOARD

CHART 1: Identifying a Suspected Concussion – Steps and Responsibilities



SUDBURY CATHOLIC DISTRICT SCHOOL BOARD

CHART 2: Diagnosed Concussion – Stages and Responsibilities

Student:
CONCUSSION DIAGNOSED

Principal/Designate:
Informs appropriate school staff of the diagnosis, and meets with parent/guardian to provide and explain the Home Preparation for RTS and RTPA Plan (Appendix C)

Home Preparation for Return to School (RTS) and Return to Physcial Actvity (RTPA) Plan (Appendix C) – completed at home

Parent/Guardian:
Reports to principal/designate that student has completed:
Stage 2 RTS
Stage 2b RTPA

Student returns to school to begin the School Concussion Management Plan – Return to School (RTS) and Return to Physical Activity (RTPA) Plan (Appendix D) – completed at school

Principal/Designate:
Meets with parent/guardian to: provide and explain the purpose of Appendix E, explain the Collaborative Team approach and their role with the team

Student:
Returns to School
Student conference to develop RTS and RTPA Plan

Return to School – Stage 3a
Student: attends school (2 hours) with adaptations of learning strategies and/or approaches

Return to School – Stage 3b
Student: attends school ½ time with moderate workload

Return to School – Stage 4a
Student: attends full day school with adaptations of learning strategies and/or approaches

Return to School – Stage 4b
Student: attends full day school without adaptations of learning strategies and/or approaches
RTS Complete

Return to Physical Activity – Stage 3
Student: simple locomotor activities/sport-specific exercise to add movement

Return to Physical Activity – Stage 3
Student: simple locomotor activities/sport-specific exercise to add movement

Collborative Team Lead/Designate:
Report to parent/guardian completion of Stage 4b RTS and Stage 4 RTPA and provides Documentation for Medical Clearance (Appendix E)

Parent/Guardian:
Provides principal with signed Medical Clearance (Appendix E)

Return to Physcial Activity – Stage 5
Student full particpatiion in physical activities (physical education, intramurals, non-contact interschool sports) and full contact training/practice in contact sports

Return to Physcial Activity – Stage 6
Student: unrestricted return to contact sports - RTPA - Complete

At the completion of each stage student progress is documented with results shared between school and home. Parent/guardian confirms completion of each stage by returning D with a signature. At each stage student is monitored for return of symptoms, new and worsening symptoms. During RTS Stages 1-4b and RTPA 1-4, if the student exhibits/reports return of symptoms or new symptoms student must return to the previous stage for a minimum of 24 hours. If during any Stage the student exhibits or reports worsening symptoms, student must return to medical doctor/nurse practitioner.

During RTPA Stages 5 and 6, if student exhibits a return of symptoms or new symptoms the student must obtain Medical Clearance reassessment

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Concussion Code of Conduct for Coaches and Team Trainers

I can help prevent concussions through my:

- Efforts to ensure that my athletes wear the proper equipment and wear it correctly.
- Efforts to help my athletes develop their skills and strength so they can participate to the best of their abilities.
- Respect for the rules of my sport or activity and efforts to ensure that my athletes do, too.
- Commitment to fair play and respect for all (respecting other coaches, team trainers, officials and all participants and ensuring my athletes respect others and play fair).

I will care for the health and safety of all participants by taking concussions seriously. I understand that:

- A concussion is a brain injury that can have both short- and long-term effects.
- A blow to the head, face, or neck, or a blow to the body may cause the brain to move around inside the skull and result in a concussion.
- A person doesn't need to lose consciousness to have had a concussion.
- An athlete with a suspected concussion should stop participating in training, practice or competition **immediately**.
- I have a commitment to concussion recognition and reporting, including self-reporting of possible concussion and reporting to a designated person when an individual suspects that another individual may have sustained a concussion.
- Continuing to participate in further training, practice or competition with a suspected concussion increases a person's risk of more severe, longer lasting symptoms, and increases their risk of other injuries or even death.

I will create an environment where participants feel safe and comfortable speaking up. I will:

- Encourage athletes not to hide their symptoms, but to tell me, an official, parent or another adult they trust if they experience any symptoms of concussion after an impact.
- Lead by example. I will tell a fellow coach, official, team trainer and seek medical attention by a physician or nurse practitioner if I am experiencing any concussion symptoms.
- Understand and respect that any athlete with a suspected concussion must be removed from sport and not permitted to return until they undergo a medical assessment by a physician or nurse practitioner and have been medically cleared to return to training, practice or competition.
- *For coaches only*: Commit to providing opportunities before and after each training, practice and competition to enable athletes to discuss potential issues related to concussions.

I will support all participants to take the time they need to recover.

- I understand my commitment to supporting the return-to-sport process.
- I understand the athletes will have to be cleared by a physician or nurse practitioner before returning to sport.
- I will respect my fellow coaches, team trainers, parents, physicians and nurse practitioners and any decisions made with regards to the health and safety of my athletes.

By signing here, I acknowledge that I have fully reviewed and commit to this Concussion Code of Conduct.

Print Name: _____ **School:** below to insert image

Coach/Team Trainer: _____

Official: _____

Date: _____

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Concussion Code of Conduct for Athletes and Parents/Guardians (for athletes under 18 year of age)

I will help prevent concussions by:

- Wearing the proper equipment for my sport and wearing it correctly.
- Developing my skills and strength so that I can participate to the best of my ability.
- Respecting the rules of my sport or activity.
- My commitment to fair play and respect for all (respecting other athletes, coaches, team trainers and officials).

I will care for my health and safety by taking concussions seriously, and I understand that:

- A concussion is a brain injury that can have both short- and long-term effects.
- A blow to my head, face or neck, or a blow to the body that causes the brain to move around inside the skull may cause a concussion.
- I don't need to lose consciousness to have had a concussion.
- I have a commitment to concussion recognition and reporting, including self-reporting of possible concussion and reporting to a designated person when and individual suspects that another individual may have sustained a concussion. (Meaning: If I think I might have a concussion I should stop participating in further training, practice or competition **immediately,** or tell an adult if I think another athlete has a concussion).
- Continuing to participate in further training, practice or competition with a possible concussion increases my risk of more severe, longer lasting symptoms, and increases my risk of other injuries.

I will not hide concussion symptoms. I will speak up for myself and others.

- I will not hide my symptoms. I will tell a coach, official, team trainer, parent or another adult I trust if I experience **any** symptoms of concussion.
- If someone else tells me about concussion symptoms, or I see signs they might have a concussion, I will tell a coach, official, team trainer, parent or another adult I trust so they can help.
- I understand that if I have a suspected concussion, I will be removed from sport and that I will not be able to return to training, practice or competition until I undergo a medical assessment by a medical doctor or nurse practitioner and have been medically cleared to return to training, practice or competition.
- I have a commitment to sharing any pertinent information regarding incidents of removal from sport with the athlete's school and any other sport organization with which the athlete has registered (Meaning: If I am diagnosed with a concussion, I understand that letting all of my other coaches and teachers know about my injury will help them support me while I recover.)

I will take the time I need to recover, because it is important for my health.

- I understand my commitment to supporting the return-to-sport process (I will have to follow my sport organization's Return-to-Sport Protocol).

- I understand I will have to be medically cleared by a medical doctor or nurse practitioner before returning to training, practice or competition.
- I will respect my coaches, team trainers, parents, health-care professionals, and medical doctors and nurse practitioners, regarding my health and safety.

By signing here, I acknowledge that I have fully reviewed and commit to this Concussion Code of Conduct.

Print Name: _____ **School:** _____

Athlete: _____

Parent/Guardian (of athletes who are under 18 years of age): _____

Date: _____