



POTENTIALLY LIFE-THREATENING MEDICAL CONDITIONS

GOVERNANCE POLICY

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1. PRINCIPLES

1. The South Shore Regional Centre for Education (SSRCE) recognizes that students may have medical conditions that could potentially become life-threatening while they are attending school and school activities. A potentially life-threatening illness is defined as any chronic illness, medical condition or allergy, such as diabetes, severe allergies, epilepsy, and asthma, that in certain conditions, when left untreated or improperly treated, could lead to death.
2. The SSRCE believes in respecting the confidentiality and dignity of students with potentially life-threatening medical conditions.
3. The SSRCE will comply with interdepartmental protocols for the provision of potentially life-threatening medical conditions.

2. POLICY FRAMEWORK

1. This policy complies with the Education Act and other related provincial acts and policies.
 1. SSRCE Policy 286: Administration of Prescription/Non-Prescription Medication to Students
 2. [Individual Medical Care Plan for Students with a Life-Threatening Illness \(Canadian Diabetes Association\)](#)
 3. [Guidelines for Supporting Students with Type 1 Diabetes \(and Other Diabetes Requiring Insulin\) in Schools](#)
 4. [Diabetes Management and Emergency Plan of Care for Students with Type 1 Diabetes, Annapolis Valley Regional School Board and Annapolis Valley Health](#)
 5. [Anaphylaxis in Schools and Other Settings, 2011 Canadian Society of Allergy & Clinical Immunology](#)
 6. [Standards of Care for Students with Type 1 Diabetes in School, 2008, Canadian Diabetes Association](#)
 7. [Canadian Diabetes Association 2008 Clinical Practice Guidelines](#)
 8. [Epilepsy Toronto, All about Epilepsy On-line Course](#)
 9. [The Epilepsy Foundation](#)
 10. [Epilepsy, A Guide for Families \(Neurology Division of the IWK Health Center\)](#)
 11. [The Lung Association of Canada](#)

12. [School Policy Guidelines for Asthma](#)
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25. Record of Staff Training (Appendix “F”)

3. **AUTHORIZATION**

The Regional Executive Director is authorized to issue procedures in support of this policy.

POTENTIALLY LIFE-THREATENING MEDICAL CONDITIONS

ADMINISTRATIVE PROCEDURES

CONTENTS

1. PROCEDURES
2. RESPONSIBILITIES

1. PROCEDURES

1. Every school principal will ensure upon registration that parents/guardians and students are asked to supply information on any potentially life-threatening medical conditions. Parents/Guardians are responsible to ensure that the principal is aware of any potentially life-threatening medical conditions.
2. The principal or designate will ensure that an Emergency Plan specific to the medical condition identified is developed for each student using the Emergency Plan templates (Appendices “A²”, B², C², and D²). Emergency Plans for individual students should be made in consultation with parents/guardians and medical professional staff, such as the Liaison for Students with Health Care Needs.
3. Student-specific Emergency Plans must be signed by an authorized health care professional. This could include a physician, nurse practitioner, nurse in a specialized clinic, or the Liaison for Students with Health Care Needs.
4. Emergency Plans will be posted, with the student’s picture for identification, in areas such as the office and staff room. The principal or designate will ensure that any SSRCE staff that provide supervision of these students must be made aware of the medical condition and have a copy of the Emergency Plan if they do not have access to posted copies (e.g.: bus driver, bus garage). The principal or designate will also ensure a mechanism is in place to notify substitute staff of students with potentially life-threatening medical conditions.
5. Each student’s Emergency Plan is to be reviewed and signed annually by parents/guardians at the beginning of each school year and updated as required. If no changes to the Emergency Plan are required, the parent/guardian may complete the Emergency Plan Annual Review Sheet (Appendix “E”) each year.
6. Parents/Guardians must inform the school, in writing, of any changes in a health condition, treatment method, and/or emergency care routine required for their child while attending school.
7. It is the responsibility of the school principal to ensure prevention strategies are identified and in place to prevent medical emergencies from occurring whenever possible.
8. Students’ independence in providing their own care will be supported and encouraged whenever possible. Daily medical management will be implemented in the least intrusive way for the student as possible.
9. Students are strongly encouraged to wear medical alert identification at all times.

10. Parents/Guardians must provide necessary medication and health care supplies for the student during the school day and while participating in school activities. The SSRCE will not be held accountable for any ill effects if a parent/guardian has failed to provide these supplies or medication. Medication is to be administered as outlined in the student's Emergency Plan and in accordance with SSRCE Policy 286: Administration of Prescription/Non-Prescription Medication to Students. Medication is to be used for only those students for which it is prescribed.
11. Medication or supplies that may be required in an emergency, such as glucagon, epinephrine auto injectors, inhalers, juice packs (or other sugar sources), or blood glucose testing equipment, are not to be kept in a locked location, but somewhere in the school that is clearly marked and accessible to school staff during the school day and school activities. If the student leaves the school for school activities, it is ultimately the responsibility of the supervising school staff to ensure they have the necessary medical supplies in the event an emergency should occur. This responsibility is shared with the student, as age and maturity appropriate.
12. The principal is responsible to ensure annual emergency response training regarding the management of potentially life-threatening illnesses occurs for all school staff in direct contact with students diagnosed with a potentially life-threatening medical condition. This training should be completed by a medical professional whenever possible and recorded on the Record of Staff Training (Appendix "F"). It is recommended that the principal maintain a record of trained staff.

2. RESPONSIBILITIES

It shall be the responsibility of the Regional Executive Director to ensure these administrative procedures are followed

Appendix “A1”

Anaphylaxis

The following information has been referenced from *Anaphylaxis in Schools and Other Settings*, (2009), Canadian Society of Allergy & Clinical Immunology.

Definition: Anaphylaxis is a severe allergic reaction that can cause death. During anaphylaxis, there is a rapid reaction involving one or more body systems when a person is exposed to an allergen. The body’s immune system recognizes the allergen as something that needs to be rejected, causing the allergic reaction. The most common allergens are foods (peanuts, tree nuts (e.g.: almond, hazelnut, cashew, and pistachio), milk, egg, fish, shellfish, sesame seeds, soy, and wheat) and insect stings (e.g.: bees, wasps, and hornets). Medications and latex can also cause life-threatening allergic reactions.

Signs and Symptoms: The following signs and symptoms can occur within minutes or, more rarely, several hours after exposure. Signs and symptoms vary from person to person and from attack to attack in the same person. An anaphylactic reaction can cause any of the following symptoms alone or in any combination:

- Skin – hives, itching, swelling, warmth, rash, redness (hives are not always present).
- Respiratory (breathing) – wheezing, shortness of breath, throat tightness, cough, hoarse voice, chest pain/tightness, nasal congestion, hay fever-like symptoms (runny, itchy nose and watery eyes, sneezing), trouble swallowing.
- Gastrointestinal (stomach) – nausea, pain/cramps, vomiting, diarrhea.
- Cardiovascular (heart) – pale/blue color, weak pulse, passing out, dizzy/lightheaded, shock.
- Other – anxiety, feeling of “impending doom”, headache, uterine cramps in females.

The most life-threatening symptoms of an allergic reaction involve breathing problems caused by swelling of the airways and a drop in blood pressure resulting in dizziness, lightheadedness, and feeling faint or weak.

If an allergic person tells you they think a reaction may be happening, take them seriously. Early symptoms should never be ignored. Respond immediately as outlined in their Anaphylaxis Emergency Plan.

Six Key Recommendations for Dealing with Anaphylaxis

1. Epinephrine is the first line medication that should be used in the emergency management of a person having a potentially life-threatening allergic reaction. **Auto injectors must be kept in locations that are easily accessible and not in locked cupboards.** The location must be known by all staff and indicated on their Anaphylaxis Emergency Plan. It is strongly preferred that students with the allergy carry their auto injector on them at all times when the parent/guardian deems they are mature enough to do so (usually by age 6 or 7).
2. Antihistamines and asthma medications must not be used as first line treatment for an anaphylactic reaction.
3. Students who have received emergency epinephrine must be transported to the hospital immediately.

Appendix “A1”

4. Additional epinephrine should be available during transport. Students prescribed epinephrine are advised to have at least one epinephrine auto-injector with them at all times. Ideally, students should have access to a back-up auto-injector in case a second dose is required.
5. It is important that the student not be made to sit or stand immediately following a reaction, as this could result in a drop in blood pressure. If they are feeling faint or dizzy, they should lie on their side, unless vomiting or experiencing severe respiratory distress. They may need to sit up where they are laying if this happens.
6. No one should be expected to be fully responsible to self-administer an epinephrine auto-injector.

Life-Threatening Allergy (Anaphylaxis) Prevention

The prevention and management of severe allergic reactions is a shared responsibility between the student, family, and school staff. It is possible and extremely important to reduce the risk of exposure of the anaphylaxis causing allergen to the allergic individual. For food-allergic individuals, the key to remaining safe is avoidance of the food allergen. Very small or even minute amounts of certain foods can cause severe reactions when ingested. For fish and shellfish, vapor or steam that contains proteins emitted from cooking have been shown to trigger asthmatic reactions and even anaphylaxis.

It is important to note that food restrictions alone do not take the place of effective risk reduction strategies. The emphasis should be on preventing an allergic emergency through education, awareness, training, and being prepared to respond during an emergency. Even in schools that have implemented a restriction on allergy producing products, such as peanuts and nuts, parents/guardians should teach food-allergic children to stick to strict safety rules (not sharing or accepting food, carrying epinephrine, etc.). Schools can be expected to create an “allergy-safe” environment. It is unrealistic, however, to expect an “allergen-free” environment.

For more information on avoidance strategies to use in preventing allergic reactions, refer to <http://www.allergysafecommunities.ca/pages/default.asp?catid=19>. Avoidance strategies that differ from those outlined on this website must be deemed achievable by the school principal.

Responsibilities in Allergy Prevention and Management

The management of students who have severe allergies requires a clear understanding of the responsibilities of student, families, school staff, and health personnel.

Responsibilities of Students at Risk:

- Have at least one auto-injector at school with their name on it, preferably carried on them at all times.
- Learn how to use their auto-injector.
- Wear medical identification, such as a MedicAlert® bracelet.
- Do not play with auto injectors.
- Do not eat if auto-injector is not handy.
- Never trade or share food, eating utensils, or containers with others.
- Eat food on a napkin or placemat.
- For younger children, eat in the same location each day.
- Be very cautious when eating foods prepared by others (older children).
- Always read food labels and eat only safe foods. If unsure, check with parent/guardian before eating.

Appendix “A1”

- Ask about the preparation of foods at school.

Responsibilities of Parents/Guardians:

- Teach their allergic child avoidance strategies and practice these strategies.
- Inform the school about the child’s allergies and update the school of any changes.
- Provide the child and/or school with at least one epinephrine auto-injector that is not expired.
- Keep a log of expiry dates and replace outdated auto-injectors.
- Ensure children with food allergies eat only approved foods.
- Ensure children try new foods at home before eating them at school.
- Complete an Anaphylaxis Emergency Plan with student’s photograph, allergy information, emergency contact numbers, and emergency protocol. Sign and review each school year.
- Provide consent for school staff to use an epinephrine auto-injector when they consider it necessary in an allergic emergency.
- Provide non-perishable foods for the food-allergic child (in case the child’s lunch is forgotten) and safe snacks for special occasions to be kept at school.
- Work with school staff to establish field trip arrangements.

Responsibilities of Principals and School Staff:

- Be aware of students who have life-threatening allergies and what to do if a reaction occurs.
- Ensure adult supervision while young students are eating.
- Clean surfaces such as tables, toys, etc. before and after eating.
- Encourage everyone to wash their hands before and after eating.
- Work with food service staff to ensure food being served is appropriate.
- Modify or restrict the use of foods for special events when needed.
- Ensure that each student completes an Anaphylaxis Emergency Plan.
 - Ensure that Anaphylaxis Emergency Plans are shared with staff and are posted in an area that respects the students’ privacy.
- Set up annual training for school staff regarding anaphylaxis management.
- All school staff attend annual anaphylaxis training, which includes the identification of students at risk and how to use an epinephrine auto-injector.
- Ensure all staff have access to the students’ Anaphylaxis Emergency Plans and Epi Pens.
- Encourage a no eating rule on the bus.

Responsibilities of Health Personnel:

- Support Anaphylaxis Emergency Plan development, as required.
- Provide student specific information as required, as per Board policy.
- Be a resource in the training of school staff.

Training

All school staff in regular contact with students at risk of anaphylaxis should participate in annual standardized training sessions, preferably at the beginning of the school year. The principal or designate should keep a record of staff that have completed training and the date of that training. Training should include ways to reduce the risk of exposure, recognition of signs and symptoms of anaphylaxis, and when and how to give the epinephrine auto-injector.

Appendix “A1”

It is beneficial for participants to role play an emergency situation, similar to practicing a fire drill. This allows people to become familiar with the emergency procedure for dealing with an anaphylactic reaction, identify areas of improvement, and increase confidence in their ability to respond appropriately.

To view a refresher video on the use of the epi pen, visit www.epipen.ca, and for the twinject, go to www.twinject.ca. Viewing this video does not replace attending a training session.

For example, letters for parents or further information, refer to the document “Anaphylaxis in Schools and Other Settings” at www.allergysafecommunities.ca/pages/default.asp?catid=11

Appendix "A²"

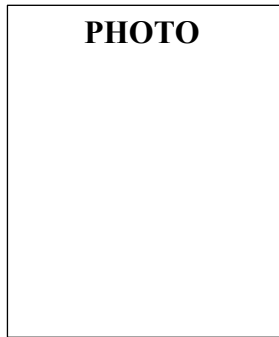
Anaphylaxis Emergency Plan

Anaphylaxis Emergency Plan for: _____

School: _____ Grade: _____ Bus #: AM _____ PM: _____

This person has a potentially life-threatening allergy (anaphylaxis) to :

Check the appropriate boxes.)



- Peanut
- Tree Nuts
- Egg
- Milk
- Other:
- Insect Stings
- Latex

Food: The key to preventing an anaphylactic emergency is absolute avoidance of the allergen. People with food allergies should not share food or eat unmarked/bulk foods or products with a "may contain" warning.

Epinephrine Auto-Injector Expiry Date: _____

- Dosage: EpiPen® Jr 0.15 mg
- Twinject® 0.15 mg
- Allerject™ 0.15 mg
- EpiPen® 0.30 mg
- Twinject® 0.30 mg
- Allerject™ 0.30 mg

Location of Auto-Injector(s):

- Previous anaphylactic reaction: Person is at greater risk.
- Asthmatic: Person is at greater risk. If person is having a reaction and has difficulty breathing, give epinephrine auto-injector before asthma medication.

A person having an anaphylactic reaction might have ANY of these signs and symptoms:

- Skin system: hives, swelling, itching, warmth, redness rash.
- Respiratory system (breathing): 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.
- 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, uterine cramps, metallic taste.

Early recognition of symptoms and immediate treatment could save a person's life.

Act quickly. The first signs of a reaction can be mild, but symptoms can get worse very quickly.

1. **Give epinephrine auto-injector** (e.g., EpiPen®, Twinject® or Allerject™) at the first sign of a known or suspected anaphylactic reaction. (See attached instruction sheet.)
2. **Call 911** or local emergency medical services. Tell them someone is having a life-threatening allergic reaction.
3. **Give a second dose of epinephrine** in 5 to 15 minutes IF the reaction continues or worsens.
4. **Go to the nearest hospital immediately (ideally by ambulance)**, even if symptoms are mild or have stopped. The reaction could worsen or come back, even after proper treatment. Stay in the hospital for an appropriate period of observation as decided by the emergency department physician (generally about 4 hours).
5. **Call emergency contact person (e.g. parent, guardian).**

Emergency Contact Information

Name	Relationship	Home Phone	Work Phone	Cell Phone

The undersigned patient, parent, or guardian authorizes any adult to administer epinephrine to the above-named person in the event of an anaphylactic reaction, as described above. This protocol has been recommended by the patient's physician.

Parent/Guardian Signature

Principal Signature

Health Care Professional Signature

Date

Date

Date

Appendix “A²”

ANAPHYLAXIS CHECKLIST

Information and Awareness

- Anaphylaxis Emergency Plan completed, posted in key locations, and shared with appropriate staff
- Anaphylactic student identified to all staff
- All school staff are aware of EpiPen/Twinject location(s), including bus drivers

In-service, including training in use of auto-injector for (annual training recommended)

- Teaching staff
- Non-teaching staff (duties, lunch monitors)
- Substitute teachers
- Bus drivers
- Cafeteria staff
- Others

Letters asking for cooperation/information sharing sent to (when appropriate)

- Parents/Guardians of children in class
- All parents in school, available at www.allergysafecommunities.ca/pages/default.asp?catid=11
- Parent organizations

Avoidance

- Allergen-free areas established
- Safe lunchroom and eating area procedures established
- Staff alerted to non-food allergens in school
- Procedures for holidays and special celebrations established
- Procedures for field trips established
- School bus procedures established

Emergency Response

- Anaphylaxis Emergency Plan posted and on file for each anaphylactic student
- Rapid communication strategy in place
- Auto-injectors stored in safe and accessible location (preferably carried by/on the student)
- School bus emergency procedure in place
- Role-playing session implemented
- Review process in place
- Review technique to administer EpiPen or Twinject periodically (www.epipen.ca or www.twinject.ca)

Appendix “B1”

Insulin Dependent Diabetes (Type 1)

Definition: Usually diagnosed in children and adolescents, Type 1 Diabetes occurs when the pancreas is unable to produce insulin. Insulin is a hormone that is required to convert glucose to energy for the body to use. The amount of glucose (sugar) in the blood at a given time is called the blood glucose level. Children with diabetes self-monitor their blood glucose regularly with a glucose meter and strive to keep the results within a target range. Their blood glucose levels will change depending on food consumption, physical activity, stress, illness, problems with the insulin delivery system, and many other unknown factors.

This administrative procedure would also apply to students who have Type 2 Diabetes who require insulin.

Diabetic Emergencies: Students with diabetes can have two types of diabetic emergencies occur – hypoglycemia and hyperglycemia. When they are either hypoglycemic or hyperglycemic, they are cognitively impaired and therefore may be physiologically unable to realize an emergency situation. Variations in a student’s blood sugar level can interfere with a student’s ability to learn, their social relationships, and participation in school activities.

Hypoglycemia, or “low blood glucose”, is an emergency situation requiring immediate action. It occurs when the amount of blood glucose (sugar) has dropped below normal range. Hypoglycemia is to be treated when blood glucose levels are less than 4, or if there are symptoms of a low blood sugar with a blood glucose level between 4 and 6. Hypoglycemia can be the result of too much insulin, too little food, or exercise without extra food. It can be mild, moderate, or severe. A school action plan must be in place before a child attends school to ensure quick treatment if hypoglycemia occurs before it becomes a more serious emergency.

Mild to moderate hypoglycemia is common in school. Symptoms can easily be misinterpreted by the student and school personnel, placing the student at serious risk of severe hypoglycemia. Signs and symptoms of mild to moderate hypoglycemia include:

- Cold, clammy or sweaty skin, paleness
- Difficulty concentrating
- Shaky, lack of coordination, staggering gait
- Irritable, tiredness (e.g.: head on desk), nervousness
- Very hungry
- Headache, blurred vision
- Abdominal pain or nausea

Severe hypoglycemia at school is rare but staff must know how to respond quickly. If hypoglycemia is not recognized and treated when mild to moderate, it can quickly progress to severe. Severe hypoglycemia is an emergency situation and often requires the administration of glucagon needle. It is recommended that at least two school personnel be trained to administer glucagon, particularly if the emergency response time (911) is not guaranteed to be less than 20 minutes. Signs and symptoms of severe hypoglycemia include:

- unable to take food by mouth
- seizures

Appendix “B1”

- fainting, unconsciousness

For the treatment of hypoglycemia, please refer to the student’s Diabetes Management Emergency Plan.

Hyperglycemia, or “high blood glucose”, is when the amount of blood glucose (sugar) is higher than an individual’s target range. An urgent response to hyperglycemia may be necessary when a person is feeling unwell with their hyperglycemia. If this occurs, school staff will contact the parent/guardian, who will take the student home or arrange for the administration of insulin. Signs and symptoms of hyperglycemia are:

- abdominal pain
- unusually tired
- unable to concentrate
- thirst
- needing to use the washroom frequently

For more information on the treatment of hyperglycemia, refer to the student’s Diabetes Management Emergency Plan.

Most students will be taking multiple doses of insulin by syringe, insulin pen, or an insulin pump each day. Often, they must administer insulin while in school. School staff do not administer insulin by needle or pen. Staff should observe students administering their own insulin once the student has been trained by a qualified individual to do so. If students are not able to administer their own insulin and require it while attending school, parents/guardians must administer insulin or make alternative arrangements.

Responsibilities for Diabetes Management at School

The prevention, identification, and treatment of low blood glucose are necessary in the daily management of diabetes. Diabetes management at school has shared responsibilities among the student, parents/guardians, school board staff, and health care professionals.

Responsibilities of Parents/Guardians and Student:

- Inform the school your child has diabetes when beginning school.
- Meet with appropriate school staff to develop a Diabetes Management Emergency Plan.
- Review and update annually the student’s Diabetes Management Emergency Plan.
- In cooperation with the school, arrange for a regular diabetes education and training in-service for all school personnel who come into contact with the student with diabetes.
- Ensure student wears medical alert identification at all times.
- Inform school staff of your child’s symptoms of hypoglycemia/hyperglycemia.
- Provide all snacks and supply fast-acting glucose for treating hypoglycemia.
- Provide all blood testing supplies in good working order every day. A diabetic child is not to be at school without blood glucose monitoring equipment.
- Label foods if needed for carbohydrate counting or to indicate snacks and meals.
- Communicate morning blood glucose levels, if requested.
- Provide a supply of glucagon and arrange for glucagon injection training by a medical professional, if required and school staff agree to administer. Replace glucagon before expiration date.
- Provide Sharps container, available from any pharmacy, for safe disposal of sharps at school.
- Strive for independence in diabetes care while at school (usually by grade 5), although support may be needed for hypo/hyperglycemia management at any age.

Appendix “B1”

- Ensure Diabetes Management Emergency Plans are in place for the administration of insulin, if needed.
- The student is to always report signs/symptoms of hypoglycemia to school staff.
- The student is to keep a source of fast-acting glucose with them at all times.
- The student is to take as much responsibility for their daily management as they are able.

Responsibilities of School Administrator:

- Arrange and attend annual diabetes in-servicing on identifying hypo/hyperglycemia and emergency procedures for treating mild, moderate, to severe hypoglycemia.
- Develop a student’s Diabetes Management Emergency Plan in collaboration with parents/guardians, the student, and health care professional, as appropriate. Review the Diabetes Management Emergency Plan annually.
- Ensure there is communication between school staff and parent/guardians regarding any incidents of hypo/hyperglycemia or other issues.
- Identify students with diabetes to all school personnel, including substitute teachers. Ensure students’ Diabetes Management Emergency Plans are posted in discrete locations that school staff access on a regular basis.
- Ensure at least two staff are trained to administer glucagon, especially if response time of emergency responders is greater than 20 minutes.
- Ensure appropriate storage of glucagon – not in a locked cupboard – and notify parents/guardians when glucagon kit is nearing its expiration date.

Responsibilities of School Staff:

- Attend annual diabetes training that includes the identification of students at risk and how to prevent or respond to a diabetic emergency.
- Permit flexibility in school rules so that a student with diabetes is able to check blood glucose conveniently, privately, and safely, whenever required. It is preferable that testing occurs in the classroom.
- Offer support for hypo/hyperglycemia management at any age.
- Permit students to treat hypoglycemia anywhere, and at any time.
- Call 911 when the treatment of severe hypoglycemia is required.
- Immediately notify parents/guardians if the student is unable to eat or vomits at school. If student vomits and parents/guardians are unavailable, take student to the nearest hospital.
- Perform blood glucose monitoring by mutual agreement with parents/guardians, provided they have appropriate training. Assistance with blood glucose monitoring may be required by very young students, those with moderate to severe hypoglycemia, or students with special needs.
- Encourage independence for students to do their own care as much as possible.
- Never leave a student alone who is, or suspected to be, hypoglycemic and ensure school staff is present for at least 30 minutes after the treatment. Once the blood sugar level is within target range and Diabetes Management Emergency Plan implementation is complete, the student may return to regular activities.
- Provide adequate supervision for school functions, such as field trips or intramural activities. Students with diabetes can participate in all school activities with proper precautions.
- If a student has a high blood sugar level and feels well, they may participate in Physical Education, but school staff should never use exercise as a treatment to bring down blood glucose levels.

Appendix “B1”

- Provide reasonable notice to parents/guardians of changes in school routines, such as special events.
- Provide students with a clean, comfortable, and private area to do blood glucose monitoring and insulin administration.
- If a student’s blood glucose level is higher than normal, allow the student to have unlimited sugar free drink, such as water, and washroom use.
- Communicate all incidences of hypoglycemia or hyperglycemia to parents/guardians.
- For elementary students, ensure all snacks and meals are eaten on time and supervise to ensure they eat their food. If the student’s blood sugar level is high, they do not need to finish meals and snacks but should eat at least half. If the student is on a regime in which they receive insulin based on carbohydrates in their lunch **before** eating (e.g. insulin pump), they must eat all their food regardless of blood sugar reading.
- Provide safe and readily accessible storage of the student’s snack supply. Have a supply of fast-acting glucose labeled and in several locations throughout the school.
- Ensure the student does not participate in Physical Education or exams if blood glucose is below 4. If blood sugar is above 17 and the student is feeling unwell, contact parents/guardians prior to physical activity or completing exams.
- Notify parents/guardians immediately when student is treated for moderate or severe hypoglycemia and blood sugar does not return to normal after one treatment.
- Never withhold food packed in student’s lunch based on the student’s blood sugar level.

Appendix "B"

Diabetes Management Emergency Plan

PHOTO

Name: _____ School: _____
Grade: _____ DOB: _____ Medical Alert #: _____
Bus Number: a.m. _____ p.m.: _____

Blood Sugar Monitoring Procedure

The student will check blood sugars at the following times:

- a.m. p.m.
- a.m. p.m.

The following staff member is responsible for monitoring the blood sugar level when the student is symptomatic and/or following treatment for low blood sugar:

*Blood sugar levels may also be checked by this person if there is a concern prior to or following Physical Education or physical activity.

Action Plan

For a blood sugar below 4 (may be 6 for young students):

- Give sugar source*, such as juice pack, right away.
- Re-test blood sugar in 15 minutes. If it is still below 4, repeat the sugar source and contact the parent/guardian. The student is not to participate in physical activity when the blood sugar level is below 4.
- If the school is unable to contact the parent/guardian and the sugar level remains low, medical attention will be obtained if deemed necessary.
- If blood sugar goes below 4 within 30 minutes before snack or lunch, eat snack or lunch as soon as the blood sugar level is above 4.
- If blood sugar goes below 4 and it is more than 30 minutes before snack or lunch, give extra snack as soon as blood sugar level is above 4.

If blood sugar returns to normal range (between 4 and 12) and student has no symptoms of low or high blood sugar, resume regular activities.

The symptoms of low blood sugars are paleness, sweating, shaking, blurred vision, dizziness, headaches, complaining of feeling hungry, mood changes, and stating "I feel low".

Extra sugar sources, such as juice packs, will be kept _____.

For a blood sugar over 17:

- Continue with regular activity as long as the student is feeling well, not experiencing abdominal pain or fatigue, or is unable to concentrate.
- Allow the student to drink as much water or sugar free liquids as they would like and to use the bathroom whenever needed. High sugars can increase thirst and voiding.
- The student may participate in any physical activities with a high sugar level, as long as they are not symptomatic (abdominal pain, unusually tired, or unable to concentrate).
- If the student's blood sugar level is high, they do not need to finish meals and snacks but should eat at least half. If the student is on a regime in which they receive insulin based on carbohydrates in their lunch **before** eating (e.g. insulin pump), they must eat all their food regardless of blood sugar reading. Parent/Guardian will ensure insulin is adjusted as required.

Appendix "B²"

At any time, if a student with diabetes:

- Looks ill or is vomiting, contact parents/guardians or emergency contact immediately. If the parents/guardians or emergency contact cannot be reached, seek medical attention.
- Becomes confused or loses consciousness, roll them onto their side and contact 911 immediately. Do not force food or drink. Give glucagon if trained staff are available to do so.

Emergency Contact Information:

Name	Relationship	Home Phone	Work Phone	Cell Phone

Patient/Parent/Guardian Signature

Principal Signature

Health Care Professional Signature

Date

Date

Date

* Examples of treatment options for mild to moderate hypoglycemia:

- 3 teaspoons of sugar dissolved in water
- ¾ cup of juice or pop
- 6 lifesavers
- 1 tablespoon of honey
- 15g of glucose in the form of glucose tabs

Appendix “B³”

Student Insulin Pump Guidelines

Insulin pumps are one method to provide insulin to someone with diabetes. Pump use is increasing as it offers several advantages over other forms of insulin delivery, such as injection or pen. The pump provides more precise insulin dosing, flexibility in meal timing, and fewer infections for the child. The decision to use a pump is made in collaboration with the student, family, and their diabetes care providers.

The pump delivers insulin in two ways:

1. A steady, pre-programmed dose of rapid acting insulin given throughout the day.
2. A rapid acting insulin bolus given manually at meals or snack time when food is eaten. (An additional bolus can be given to correct high blood sugar levels.)

Responsibilities for Student Insulin Pump Monitoring at School

It is important that staff responsible for students with diabetes using a pump at school have a basic understanding of how the pump works and how to respond to issues that occur due to pump malfunction or the student’s diabetes. Prior to supervising a student with a pump, some basic training is required. Pump training can be provided by a health care professional or a parent/guardian experienced in pump use.

Student insulin pump management at school has shared responsibilities among the student, parents/guardians, School Board staff, and health care professionals when a student is unable to manage it on their own.

Responsibilities of Parents/Guardians and Student:

- Ensure the pump, tubing, and injection site are in good working order each day.
- Ensure there is adequate insulin supply in the pump while at school.
- Provide the school with current emergency contact numbers.
- Provide information on amount of carbohydrates in each food item.
- Never request school staff to administer an insulin dose other than what is calculated by the pump.
- Ensure that any extra pump supplies the student may require are kept at school.
- Share a plan to address the pump site falling out.
- If the student is not feeling well, arrange to take him/her home to manage the diabetes.
- Report to school personnel any pump incidents, such as pump alarms, site problems, concerns with tubing, and suspected high or low blood sugar levels.

Responsibilities of School Staff:

- Follow the student’s Diabetes Management Emergency Plan.
- Assist younger students, as required, with carbohydrate counting, ensuring the correct blood sugar level and amount of carbohydrates are entered into the pump, and confirming the correct insulin dose is entered and delivered by the pump. The pump determines the dose based on the blood sugar level and carbohydrates eaten.
- Only support insulin delivery by pump when carbohydrate/blood glucose calculation program is on. Enter and administer the insulin dose that is calculated by pump.
- Notify parents/guardians in advance of activities involving extra exercise.
- Suspend the pump if low blood sugar does not resolve with treatment.

Appendix “B³”

Procedure for Managing Hyperglycemia (High Blood Sugar) with Pump Therapy

The pump only delivers rapid acting insulin; therefore students can develop complications more quickly with high blood sugar levels if not resolved. If, at any time, a student using a pump with a high blood sugar complains of abdominal pain, nausea, and/or not feeling well, their parent/guardian must be contacted immediately.

If the student is experiencing high blood sugar, check skin insertion site for leakage, dislodgement, redness, and/or tenderness. If any are noted, or if pump dysfunction is suspected, notify parent/guardian immediately, as the site likely needs to be changed. Older students may be able to do their own site change at school if they have supplies. Ensure proper disposal of used equipment.

If a bolus of insulin is delivered via the pump to treat a high blood sugar level, recheck the blood sugar level in two hours to ensure it is decreasing. If it does not decrease or if symptoms of nausea, vomiting, and/or abdominal pain develop, contact parent/guardian immediately.

Pump Alarms

Contact parent/guardian if student is unable to resolve or staff are unsure. If alarm is resolved, record the incident in the student’s communication book.

Calculating a Snack or Meal Time Bolus of Insulin via the Pump, Using the Carbohydrate/Blood Glucose Calculation Program on the Pump

A bolus can be given before or after a meal. Parents/Guardians will instruct school staff when the bolus is to be given.

1. The blood sugar level is checked prior to eating. Value is correctly entered into pump. If a student is to receive an insulin bolus before eating, ensure that it is not given more than 10 minutes before eating. If the blood sugar is less than 3.9 before a meal, do not give bolus until after eating.
2. The grams of carbohydrates in the food eaten or to be eaten are calculated and entered into the pump. If the carbohydrates are entered **before** eating, the student must eat all of their food.
3. The pump will calculate the amount of insulin to be given based on the blood sugar level and carbohydrates eaten.
4. The amount of insulin bolus calculated by the pump is entered and delivered by pushing the correct buttons.
5. Each pump has its own sequence of button pushing to deliver a bolus. School staff must receive instruction and be supervised giving a bolus prior to doing so on their own. Prior to school staff supervising a student with an insulin pump, they should know how to give a bolus, how to suspend/resume the pump, how to use the carbohydrate/blood glucose calculator and insulin delivery sequence, and when to provide extra snacks when increased activity is planned.

Pump settings are pre-programmed by the student’s health care professional. Under no circumstance are those settings to be changed by school staff.

Appendix “C1”

Seizures

Definition: Epilepsy is a disorder of the brain characterized by recurring seizures. The brain is made up of many nerve cells that communicate through electrical and chemical signals. If there is a sudden excessive electrical discharge in the brain, it can result in a seizure. The type of seizure depends on the part of the brain where the excessive electrical activity is happening. In general, seizures are painless and stop on their own. Many seizures last a few seconds and are not always noticed.

Most people with epilepsy are otherwise healthy with average intelligence. Epilepsy is not a disease, but a symptom resulting from different conditions that result in the brain cells to be over excitable, preventing the well-ordered cooperation of the brain. For students known to have a seizure disorder, a seizure is not necessarily a medical emergency. Usually, the person just needs time for the brain to settle back into to regular functioning again. The most important consideration for school staff is often ensuring the student remains safe during a seizure, as there is often loss of voluntary control of certain muscles or the entire body.

Epilepsy is often treated with medication, some of which can affect learning. Other treatments can include special diets and surgery.

Causes and Triggers: Seizures are not usually predictable and often doctors never know what causes a person’s seizures. There are certain triggers that can contribute to a seizure occurring, such as a missed dose of seizure medication, amount of sleep, hormonal changes, illnesses, including those that cause a fever, and medical conditions, such as low blood sugar. Stress, emotional upset, or flickering lights can also be triggers. Recording seizure activity and what was occurring at the time of the seizure can be helpful in determining seizure patterns, triggers, and effectiveness of seizure medication.

Different Types of Seizures: There are many different types of seizures and often more than a single type can occur in the same person. The two main types are generalized and partial. If the electrical discharge affects the whole brain, the seizure is called generalized. If it only affects part of the brain, it is called a partial seizure.

Simple partial seizures begin in one place in the brain and affect only part of the brain. Depending on where they start and which part of the brain they involve, partial seizures may or may not alter consciousness or awareness and usually last a short time. Some examples of simple partial seizures are the person seeing flashing lights, tingling or jerking of a leg or arm, an unpleasant odor, or experiencing an overwhelming emotion, such as fear.

Complex partial seizures also involve one part of the brain but deeper brain tissue resulting in a change in their level of consciousness. Examples of this type could include lip smacking, repeatedly picking at one's clothes, wandering around confused, making noises, or saying words that don't make sense. The person may respond but will not understand what is being said to them. When the seizure ends, the person may be confused and have no memory of it. This is a very common type of seizure but may not be recognized. If not spoken to and handled gently, they may lash out unknowingly in self-protection.

In **generalized seizures**, which can be convulsive or non-convulsive, there is excessive electrical activity occurring throughout the whole brain at once. Consciousness is altered. Tonic-Clonic, or convulsive

Appendix “C1”

seizures, are the type of seizure most people recognize as epilepsy. They were formerly known as “grand mal” seizures. Tonic means stiffening and clonic means jerking. This seizure begins with the tonic phase and the body's muscles stiffen. Then there is the clonic phase, when the limbs, body, and head begin to jerk rhythmically. Saliva pools in the mouth and the person may bite their tongue. They may also lose control of their bladder or bowels. It usually lasts for one to three minutes, at which time the jerking slows and the seizure ends. Consciousness is lost throughout the seizure and the person does not experience pain. Breathing should return to normal and the person is usually confused, sleepy, or irritable for a period after the seizure. They need to be permitted to rest until they fully recover. Speak to them gently and explain that they have just had a seizure.

Absence seizures are non-convulsive generalized seizures occurring most often in children, formerly known as “petit mal” seizures. They are brief staring spells that can be mistaken as day dreaming. The child loses awareness for a few seconds and becomes unresponsive. These staring spells start and stop quickly, usually lasting less than 10 seconds. There could be eye movement as well, such as eyes rolling back or eyelid fluttering. Movements of the mouth, hands, and head may also occur, especially if the seizure lasts more than 10 seconds. Often, the child is suddenly back to normal alertness and often unaware a seizure has occurred. These seizures result in lost instructional time. There can be many absence seizures during the day, resulting in frequent lapses.

Responsibilities of Students and/or Parents/Guardians:

- Meet with school staff to discuss the seizure disorder.
- Update teachers on changes in epilepsy or medication.
- Develop a Seizure Emergency Plan, as required.
- Provide emergency medication, as required.

Responsibilities of School Administrator:

- Ensure a Seizure Emergency Plan is developed.
- Post Seizure Emergency Plan and share with appropriate staff.
- Set up and attend staff training session.
- Support the execution of any special diets related to controlling epilepsy.

Responsibilities of School Staff:

- Become aware of epilepsy and how it can affect learning.
- Attend staff training sessions and know how to respond if a seizure were to occur.
- Educate and reassure students about epilepsy, as needed. Do not tolerate bullying or teasing about seizures.
- Treat a student gently following a seizure. Reassure them and explain what has happened.
- Closely monitor during Physical Education class, as needed.
- Repeat instructions often if student with absence seizures is in the class.
- Support the execution of any special diets related to controlling epilepsy.

Appendix "C2"

Seizure Emergency Plan



Name: _____ School: _____
 Grade: _____ DOB: _____ Medical Alert #: _____
 Bus Number: a.m. _____ p.m.: _____
 Seizure triggers or warning signs:
 • _____
 • _____
 • _____
 Description of past seizures: _____

Basic First Aid:

Seizure First Aid:

- Remain calm. Time seizure with clock or watch.
- Keep the student safe. Position on their side or abdomen with their head turned to either side to keep their air way open.
- Do not force objects between their teeth.
- Do not attempt to stop shaking. Restrain gently to prevent head or limbs striking against hard objects.
- Allow seizure to run its course. Do not be worried if the child stops breathing momentarily.
- If you have been instructed to administer medication during a seizure, please do so according to specific instructions.
- Stay with student until fully conscious and check for possible injuries.
- Student may bite their tongue. Bleeding from the mouth is not uncommon.

Emergency Response: Call 911

- A convulsive (tonic-clonic) seizure that lasts longer than five minutes.
- Repeated seizures without regaining consciousness.
- A seizure for anyone without epilepsy.
- Student who has the seizure is injured or has diabetes.
- Student has a seizure in water.

Emergency seizure medication to be given? Yes No

Instructions for medication*: _____

Special Considerations (regarding school activities, sports, trips, etc.): _____

Emergency Contact Information:

Name	Relationship	Home Phone	Work Phone	Cell Phone

 Patient/Parent/Guardian Signature

 Principal Signature

 Health Care Professional Signature

 Date

 Date

 Date

*** Authorization of Administration of Medication Form must be completed, as per Policy 286.**

Appendix "C³"

Seizure Log

Name: _____ Grade: _____ School: _____

Date					
Time					

Before the Seizure

Activities just before					
Setting					
Triggering factors					
Mood changes					

Seizure activity noted (check all that apply)

Aura					
Change in awareness					
Confused					
Unable to talk					
Follows commands					
Twitching					
Chewing motions					
Eyes staring					
Eyes blinking					
Eyes rolling					
Went limp					
Became stiff					
Jerking					
Fell					
Skin color flushed					
Skin color pale					
Labored breathing					
Frothing at the mouth					
Loss of bowel or bladder control					

After the Seizure

Alert					
Confused					
Sleepy					
Agitated					
Limb weakness (l or r)					
Injuries (describe)					
Duration of seizure					
Additional Comments					

Appendix “D1”

Asthma

Definition: Asthma is one of the most common chronic illnesses among children. It is an inflammatory lung disease that results in recurring episodes of coughing, wheezing, and breathing difficulties, such as shortness of breath, chest tightness, fast pulse, and increased breathing rate. During an asthma attack, the airway lining becomes swollen, resulting in increased mucus production and airway muscle spasms that cause decreased air flow.

If asthma is not well controlled, it can impact the student in various ways. A student may miss school time more frequently than their peers due to illness, have a persistent cough during the day, suffer from lack of sleep at night, have decreased stamina during physical activity, and require asthma medication during the school day. Asthma cannot be cured but it can be well controlled through the use of medicine. Communication between the school and home is important in the management of asthma, particularly with young children.

Triggers: Usually, asthma is mild to moderate, but it can become severe or life-threatening. Various conditions and situations can trigger an asthma attack, such as viral illnesses, strong emotions, cold air, physical activity, allergens such as animal dander and pollen, or cigarette smoke.

Response to Asthma Attack: It is not an expectation that every student complete an Asthma Emergency Plan due to the frequency of asthma and the fact that many students manage their own asthma. It is expected that all school staff are made aware of students who have asthma and of the procedure of managing an asthmatic attack/emergency. Physical Education teachers must be especially aware, as exercise is a common trigger for an asthma attack.

Students who have unstable or severe asthma and students who may require school staff to regularly manage their asthma must complete an Asthma Plan of Care.

Responsibilities of the Parent/Guardian and Student:

- Identify the medical condition to the school administrator.
- Keep the student home when they are not well enough to attend school.
- Work with health care providers to teach the student to self-administer their puffer, as appropriate.
- If medication is to be given at school, follow Policy 286: Administration of Prescription/Non-Prescription Medication to Students.
- Ensure the student has emergency medication (their reliever puffer) on them when required.
- Notify classroom and Physical Education teacher when not feeling well.
- Ensure the Asthma Emergency Plan is completed for students with uncontrolled asthma and any student who relies on school staff for regular asthma management.

Responsibilities of Principal and School Staff:

- Be aware of any students with asthma.
- Ensure staff have the knowledge needed to manage an asthma emergency.
- Ensure students who require an Asthma Emergency Plan have one completed.
- Remove asthma triggers from the classroom and school whenever possible.

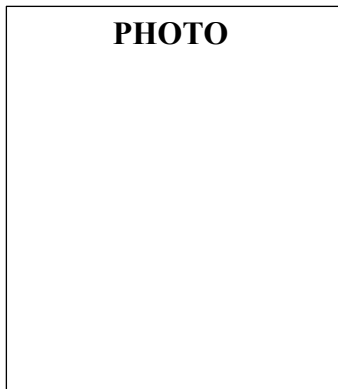
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- Notify parents/guardians of noted asthma symptoms during the school day, such as persistent/troublesome cough lasting more than a week, using their blue reliever puffer more than twice a week at school, missing school, and unusually tired in class.
- Attend, as required, asthma training that identifies students at risk and how to prevent or respond to an asthmatic emergency.

Responsibilities of Physical Education Teachers:

- Understand asthma and how it can be impacted by physical activity. Exercise can be a trigger for asthma symptoms.
- Permit students with asthma to sit out physical activity when not feeling well.
- Ensure students are permitted to use reliever asthma puffers as required, such as 10-15 minutes prior to Physical Education class, or during the class if coughing or shortness of breath occurs.

Appendix "D²"



Asthma Emergency Plan

Name: _____ School: _____
 Grade: _____ DOB: _____ Medical Alert #: _____
 Bus Number: a.m. _____ p.m.: _____
 Possible triggers for an asthma attack: _____

 Name of puffer: _____ Color of puffer: _____

Puffer must be taken:

- Before Physical Education or participating in physical activities.
- With frequent coughing When getting or during a cold

- Other (please specify): _____

During an asthma attack:

- Have the student sit down, not lay down. Keep the student calm.
- Remove asthma trigger if present.
- Have student take two puffs of their emergency medicine. The medicine should work within 10 minutes. If breathing does not improve, call 911.
- Repeat two puffs of their emergency medicine every ten minutes until the ambulance arrives. Call the parent(s)/guardian(s) or emergency contact.

Call 911 if:

- The student is unable to speak due to breathing difficulties.
- The student is short of breath when resting and use of the reliever medication (puffer) does not improve symptoms.
- The student is pale, grey or has a bluish tint to lips or finger nail beds.
- The student has continuing and/or worsening breathing problems.
- The student does not have puffer medication with them and are having breathing difficulties as indicated above.
- Staff are unable to reach emergency contacts and are unsure what to do.

Emergency Contact Information:

Name	Relationship	Home Phone	Work Phone	Cell Phone

 Patient/Parent/Guardian Signature

 Principal Signature

 Health Care Professional Signature

 Date

 Date

 Date

- Copy: Physical Education Teacher
 Classroom Teacher
 Bus Driver
 Transportation Department

*** SSRCE Policy 286: Administration of Prescription/Non-Prescription Medication to Students must be followed.**
Emergency Plan Annual Review Sheet

Appendix "E"

Name: _____ School: _____ Grade: _____ DOB: _____
 Bus a.m.: _____ Bus p.m.: _____ Medical Alert Number: _____

Emergency Plan Reviewed and Updated for the 20____-20____ school year.		
_____ Patient/Parent/Guardian Signature	_____ Authorized Health Care Professional	_____ School Principal
_____ Date	_____ Date	_____ Date

If there is no change to the student's emergency plan, please sign below and continue to follow the existing plan for the school year. If changes are required, a new emergency plan must be completed.

This plan remains in effect, without change, for the 20____-20____ school year.		
_____ Patient/Parent/Guardian Signature	_____ Authorized Health Care Professional	_____ School Principal
_____ Date	_____ Date	_____ Date

This plan remains in effect, without change, for the 20____-20____ school year.		
_____ Patient/Parent/Guardian Signature	_____ Authorized Health Care Professional	_____ School Principal
_____ Date	_____ Date	_____ Date

This plan remains in effect, without change, for the 20____-20____ school year.		
_____ Patient/Parent/Guardian Signature	_____ Authorized Health Care Professional	_____ School Principal
_____ Date	_____ Date	_____ Date

This plan remains in effect, without change, for the 20____-20____ school year.		
_____ Patient/Parent/Guardian Signature	_____ Authorized Health Care Professional	_____ School Principal
_____ Date	_____ Date	_____ Date

This plan remains in effect, without change, for the 20____-20____ school year.		
_____ Patient/Parent/Guardian Signature	_____ Authorized Health Care Professional	_____ School Principal
_____ Date	_____ Date	_____ Date

Appendix "F"

Record of Staff Training

School: _____

Date: _____

Training Topics (check all that apply):

Anaphylaxis

Diabetes

Seizures

Asthma

Other (specify): _____

Name and Title of Trainer: _____

Staff Trained:

1. _____

26. _____

2. _____

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