OCDSB 902

OTTAWA-CARLETON DISTRICT SCHOOL BOARD

Diabetes Emergency Treatment Protocol Registration

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

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

School Name:_____ Date: _____
Principal's Name: _____Home Form Teacher's Name: _____
Student's Name: _____Student No.: _____
Year/Grade: _____Pick-up/Drop-off Bus Route Numbers: _____
Location of Treatment Supplies: _____
Transportation Address: _____

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

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

_____

GENERAL COURSE OF ACTION:

- Refer to the Individual Diabetes Care Plan (attached)

CALL PARENTS/GUARDIANS:

Parent/Guardian Name:_____
Parent/Guardian Contact Number(s): _____
OR
Parent/Guardian Name: _____
Parent/Guardian Contact Number(s): _____
OR
Emergency Contact Name: _____
Emergency Contact Number(s): _____

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

_____

PARENT/GUARDIAN AUTHORIZATION RE: CONSENT TO RELEASE

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

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

- Posting of the student's photograph (physical and/or electronic) in the school so that all staff, volunteers and visitors are aware of the medical condition;
- And any such other circumstances that may be necessary to ensure the health and safety of your child.

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

Date: _____

PARENT/GUARDIAN AUTHORIZATION RE: CONSENT TO TRANSFER TO HOSPITAL

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

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

Date: _____

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

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

PRINCIPAL'S ACKNOWLEDGEMENT

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

Principal's Signature: _____

Date: _____

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