HALTON CATHOLIC DISTRICT SCHOOL BOARD CDSB

SICKLE CELL ANEMIA
STUDENT PLAN OF CARE

Place Student Photo Here

(PLEASE PRINT)

Student Name_____ Date of Birth _____

Grade _____ Room # _____

Medic Alert ID: Y N

Emergency Contacts (list in priority of contact) (please print):

	Name	Relationship	Daytime Phone	Alternate Phone
1.				
2.				
3.				

IDENTIFICATION AND EMERGENCY TREATMENT PLAN

DESCRIPTION OF MEDICAL CONCERN

OBSERVABLE SIGNS AND SYMPTOMS

RESPONSE/MANAGEMENT

AUTHORIZATION/CONSENT

The following will be will be shared with appropriate school staff and others, and/or posted:

- Student Plan of Care – on file in Office and Classroom Teacher
- Identification and Emergency Treatment Plan – posted in classroom
- Identification and Emergency Treatment Plan (HSTS) – shared with Halton Student Transportation Services (if applicable)
- At-a-Glance – posted in Staff Room(s); Health Room; First Aid Room; Office (as applicable)

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

Student: _____ Date: _____
(18 yrs. or older) Signature

Principal: _____ Date: _____
Signature

PLAN REVIEW

This plan remains in effect for the school year and will be reviewed annually.

Please Note: 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.

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

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.

REQUEST AND CONSENT FOR THE ADMINISTRATION OF SICKLE CELL ANEMIA INTERVENTION(S)

This form is completed when the school agrees with the parental request to administer intervention(s) for Sickle Cell Anemia. A new form is required: a) at the initiation of this process; b) at the beginning of each school year. Staff agreeing to administer Sickle Cell Anemia intervention(s) will do so according to the information in this form only.

Student Name:	Date:
Teacher:	Grade:

STATEMENT OF UNDERSTANDING

Regarding Parent Requests to provide Sickle Cell Anemia Intervention(s) to students by Employees of the School Board.

As the parent(s)/guardian of _____, I (we) accept and endorse the following terms
(print name of student)
pertaining to my (our) request for Halton Catholic District School Board employees to provide my (our) child with the medications listed in the Sickle Cell Anemia Student Plan of Care. Specifically,

I/we understand and accept that:

1. Board employees are not trained health professionals and, hence, may not recognize the symptoms of my (our) child's illness or medical condition or know how to treat the illness or medical condition;
2. I/we are responsible for providing up-to-date information to the school regarding the medical condition or illnesses treated by the medicines noted in the Sickle Cell Anemia Student Plan of Care.

REQUEST AND CONSENT FOR THE ADMINISTRATION OF SICKLE CELL ANEMIA INTERVENTION(S) & MEDICATION(S)

Insofar as it concerns my child _____, I/We:

I. Agree to comply with the responsibilities described above;
II. Request that the intervention(s) listed in the Sickle Cell Anemia Student Plan of Care be administered to my/our child according to the information provided by the prescribing physician and the information we have provided; and furthermore,
III. Release the Halton 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 Sickle Cell Anemia Student Plan of Care.

Having read and understood the information conveyed in the "Statement of Understanding" and the "Request and Consent for the Administration of Sickle Cell Anemia Intervention(s) and Medication(s)" form:
I/we agree to comply with the responsibilities described above.

Signature of Parent/Guardian: _____ Date: _____

Signature of Student: _____ Date: _____
(18 years of age or older)

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