STUDENT: _____ SCHOOL: _____

GRADE: _____ DATE OF REQUEST: _____/_____/_____
M D Y

I/We _____ / _____

the parents/guardians of _____
(Name of Student)

understand that:

- the Principal, Teacher and other school staff are not health professionals and have no more information about the medical condition of my/our child than that which has been provided to them in writing by myself/ourselves or by my/our child's physician. They are not experts in recognizing the symptoms of my/our child's medical condition or in treating it;

- to the extent possible, my/our child has been trained by me/us and by health professionals to recognize her/his need for intervention /medication and to respond to the need by requesting intervention;

- I/We are responsible for ensuring that –

  - all medical updates/changes or emergency information will be provided for the school staff immediately;
  - the teacher will be instructed concerning the incidents related to Sickle Cell Disease about which I/We wish to be informed;
  - an oral thermometer to take my child's temperature will be provided for the school;
  - pain medication prescribed for my/our child by the physician will be provided for the school.

- The specific incidents related to Sickle Cell Disease about which I/We would like to be informed are:

  - _____
  - _____
  - _____

- _____
- _____

In the event of an emergency, I/We authorize the school staff to obtain emergency services and to authorize such emergency treatments as are necessary. I/We agree to assume responsibility for all costs associated with the medical intervention.

I consent to the development of an Individual Sickle Cell Disease Action Plan for my child. This plan will outline the emergency steps that shall be taken if my child has a sickle cell disease emergency on school property or during a school or school board sponsored event.

The information contained in this plan will be shared, as necessary, with relevant individuals for my child's protection and well-being.

Individuals with whom the plan may be shared include, but are not limited to classroom teachers, occasional teachers, itinerant teachers, educational assistants, coaches, other school staff and school bus drivers.

I/We give permission to the school staff to post the Individual Sickle Cell Disease Action Plan, with a picture of my/our child, in appropriate locations within the school.

I/We have reviewed and agree to the Sickle Cell Disease Management Plan for my/our child.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____/_____/_____
Month Day Year

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

INDIVIDUAL SICKLE CELL DISEASE ACTION PLAN

STUDENT: _____

TEACHER(S): _____

GRADE: _____ ROOM: _____

PAIN MEDICATION PRESCRIBED: _____

_____

STUDENT PICTURE 2" x 3" PHOTO HEAD AND SHOULDERS

_____

NAMES OF STAFF WITH FIRST AID TRAINING: _____

_____

MEDIC ALERT #: _____

PARENT/GUARDIAN TELEPHONE #: _____

ALTERNATIVE TELEPHONE #: _____

2ND ALTERNATIVE TELEPHONE #: _____

EMERGENCY ACTION STEPS

1. If student not well, take temperature.
2. If temperature in mouth is 37.5° C or below, do pain assessment.
3. If pain assessment is less than 7 out of 10, give prescribed medication.
4. If pain is above 7 out of 10, contact parent/guardian immediately to pick up student.
5. If temperature is 38.0 ° C contact parent/guardian immediately to take student to hospital emergency department.
6. If any of the following occurs, call 9-1-1 immediately:
   - ☐ difficulty breathing;
   - ☐ difficulty speaking or slurring of speech;
   - ☐ fever greater than 39.0 ° C;
   - ☐ loss of consciousness;
   - ☐ severe headache;

HEALTHCARE TEAM

- Primary Physician: _____ Telephone #: _____
- Primary Nurse: _____ Telephone #: _____

Copy to be provided to HWSTS at HWSTS@hwcdsb.ca

FOR STUDENTS TRANSPORTED THROUGH HWSTS		
Bus Number:		Bus Company Name:
☐ Original Individual Sickle Cell Disease Action Plan	OR	☐ Revision to Existing Individual Sickle Cell Disease Action Plan

Parent/Guardian Signature: _____

Date: _____

Principal Signature: _____

Date: _____

PART II -To be completed by Parent/Guardian
(Please type or print)

This is to authorize the administration of the medication(s) prescribed by the attending physician from _____ to _____ for:
date **date**

Student's Name: _____
Birthdate: _____
Year **Month** **Day**
School: _____
Medic Alert I. D.: **Yes** _____ **No**

I give permission for my child to self-administer the medication prescribed by the attending physician.
Yes ___ **No** ___ **Signature of Parent/Guardian:** _____

I release and agree to indemnify the Hamilton-Wentworth Catholic District School Board and its staff from any liability or damages incurred by any party as a consequence of the administration or lack of administration of medication to my child.

Signature of Parent/Guardian: _____
Date: _____
(Year, **Month,** **Day)**

NOTE:
Parents are requested to PLACE MEDICATION IN INDIVIDUAL CONTAINERS, preferably those in which the medication was supplied from the pharmacist/physician.
The containers should be PROPERLY LABELLED indicating the STUDENT'S NAME AND ADMINISTRATION DIRECTIONS.
The medication will be delivered by parent/guardian, according to an agreed schedule, to the Principal or designated person for safe keeping, unless otherwise determined.
In case of **EMERGENCY**, the contact persons are:

Name _____ **Name** _____

Telephone _____ **Telephone** _____

Relationship _____ **Relationship** _____

Under The Municipal Freedom of Information and Protection of Privacy Act, 1989, information in forms and documents pertaining to a student registered/enrolled within The Hamilton-Wentworth Catholic District School Board is collected under the legal authority of The Education Act, and its Regulations, and the Ontario Student Record (O.S.R.) Guideline, 2000. This information is being collected to ensure that the educational program which is provided meets your child's needs.