Appendix A

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

To Be Completed by Parent/Guardian/Adult Student Annually
(Please Print or Type)

Student's Name: _____ Birthdate: _____

I acknowledge that the staff of the Hamilton-Wentworth Catholic District School Board are not health care 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 and/or nurse practitioner. 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 care professionals to recognize her/his own need for intervention/medication and to respond to the need by requesting intervention or by self-administering the appropriate medication.

Where feasible, my/our child is responsible for the necessary medication and equipment to address the diabetic condition.

I/we are responsible for ensuring that:

- a medical document is provided to the school outlining my/our child's diagnosis of Diabetes;
- all medical updates/changes or emergency information will be provided for the school staff immediately;
- there is a supply of fast-acting sugar (oral glucose/orange juice, etc.) at the school, provided by me/us;
- **two (2) BAQSIMI tubes, if prescribed by physician or nurse practitioner;**
- blood glucose monitoring items are contained in a safe container, labelled with my/our child's name, for transport and storage in the classroom;
- insulin injection items are contained in a safe container, labelled with my/our child's name; and,
- the teacher has been informed of the incidents relating to diabetes about which I/we wish to be informed.

The specific incidents related to diabetes about which I/we would like to be informed are:

- _____
- _____

Neither the Principal nor the staff of the school is responsible for:

- providing a supply of fast-acting sugar (oral glucose, orange juice, etc.);
- storing insulin over night;
- reading blood glucose monitors; or
- administering insulin injections.

In the event of an emergency (severe hypoglycemic incident), **I/we authorize the school staff to administer BAQSIMI and obtain emergency services as are necessary.** I/We agree to assume responsibility for all costs associated with the medical intervention.

Parent/Guardian/Adult Student Name: _____

Parent/Guardian/Adult Student Signature: _____

Date: Month _____ Day __ Year _____

Principal's Signature: _____

Posting of Photographs and Individual Diabetes Plan of Care

I consent to the posting of colour photographs of my child _____

and of medical information related to my child (Individual Diabetes Action Plan) in locations deemed appropriate by school staff, which may include the classroom, lunchroom, main office, resource room, school bus, staff room and other locations.

I consent to the posting of colour photographs of myself _____

and of medical information related to my Individual Diabetes Action Plan in locations deemed appropriate by school staff, which may include the classroom, lunchroom, main office, resource room, school bus, staff room and other locations.

Parent/Guardian/Adult Student Name: _____

Parent/Guardian/Adult Student Signature: _____

Date: Month _____ Day __ Year _____

Principal's Signature: _____

Consent to the Development of an Individual Diabetes Plan of Care

I consent to the development of an Individual Diabetes Plan of Care for my child/myself_____. This plan will outline the emergency steps that shall be taken if my child /I experiences a Diabetic reaction 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/my 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.

Parent/Guardian/Adult Student Name: _____

Parent/Guardian/Adult Student Signature: _____

Date: Month _____ Day ___ Year _____

Principal's Signature: _____

SS-02-57-INT (Copy to Documentation File of OSR and Student Medical File in main office)

This information is collected, retained, accessed and otherwise used in accordance with 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. 204, c. 3, Sched. A.