PREVALENT MEDICAL CONDITION — TYPE 1 DIABETES PLAN OF CARE

STUDENT INFORMATION

Student Name _____ Date Of Birth _____

Ontario Ed. # _____ Age _____

Grade _____ HR _____ Teacher(s)_____

Student Photo (optional)

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

TYPE 1 DIABETES SUPPORTS

Names of trained individuals who will provide support with diabetes-related tasks: (e.g. designated staff or community care allies.) _____

_____

Method of home-school communication: _____

Any other medical condition or allergy? _____

_____

Plan of Care for: _____

DAILY/ROUTINE TYPE 1 DIABETES MANAGEMENT

Student is able to manage their diabetes care independently and does not require any special care from the school.

☐ Yes ☐ No

❒ If Yes, go directly to page five (5) — Emergency Procedures

ROUTINE	ACTION
BLOOD GLUCOSE MONITORING ☐ Student requires trained individual to check BG/ read meter. ☐ Student needs supervision to check BG/ read meter. ☐ Student can independently check BG/ read meter. ☐ Student has continuous glucose monitor (CGM) ✸ Students should be able to check blood glucose anytime, anyplace, respecting their preference for privacy.	Target Blood Glucose Range _____ Time(s) to check BG: _____ _____ Contact Parent(s)/Guardian(s) if BG is: _____ Parent(s)/Guardian(s) Responsibilities: _____ _____ School Responsibilities: _____ _____ Student Responsibilities: _____
NUTRITION BREAKS ☐ Student requires supervision during meal times to ensure completion. ☐ Student can independently manage his/her food intake. ✸ Reasonable accommodation must be made to allow student to eat all of the provided meals and snacks on time. Students should not trade or share food/snacks with other students.	Recommended time(s) for meals/snacks:_____ Parent(s)/Guardian(s) Responsibilities:_____ _____ School Responsibilities:_____ _____ Student Responsibilities:_____ Special instructions for meal days/ special events:_____ _____

	Plan of Care for: _____
ROUTINE	**ACTION (CONTINUED)**
INSULIN ☐ Student does not take insulin at school. ☐ Student takes insulin at school by: ☐ Injection ☐ Pump ☐ Insulin is given by: ☐ Student ☐ Student with supervision ☐ Parent(s)/Guardian(s) ☐ Trained Individual ✸ All students with Type 1 diabetes use insulin. Some students will require insulin during the school day, typically before meal/nutrition breaks.	Location of insulin: _____ _____ Required times for insulin:_____ ☐ Before school: ☐ Morning Break: ☐ Lunch Break: ☐ Afternoon Break: ☐ Other (Specify):_____ Parent(s)/Guardian(s) responsibilities:_____ School Responsibilities: _____ Student Responsibilities: _____ Additional Comments: _____
ACTIVITY PLAN Physical activity lowers blood glucose. BG is often checked before activity. Carbohydrates may need to be eaten before/after physical activity. A source of fast-acting sugar must always be within students' reach.	Please indicate what this student must do prior to physical activity to help prevent low blood sugar: 1. Before activity: _____ 2. During activity: _____ 3. After activity: _____ Parent(s)/Guardian(s) Responsibilities: _____ School Responsibilities: _____ Student Responsibilities: _____ For special events, notify parent(s)/guardian(s) in advance so that appropriate adjustments or arrangements can be made. (e.g. extracurricular, Terry Fox Run)

	Plan of Care for: _____
ROUTINE	**ACTION (CONTINUED)**
DIABETES MANAGEMENT KIT Parents must provide, maintain, and refresh supplies. School must ensure this kit is accessible all times. (e.g. field trips, fire drills, lockdowns) and advise parents when supplies are low.	Kits will be available in different locations but will include: ☐ Blood Glucose meter, BG test strips, and lancets ☐ Insulin and insulin pen and supplies. ☐ Source of fast-acting sugar (e.g. juice, candy, glucose tabs.) ☐ Carbohydrate containing snacks ☐ Other (Please list) _____ _____ Location of Kit: _____
SPECIAL NEEDS A student with special considerations may require more assistance than outlined in this plan.	Comments:

EMERGENCY PROCEDURES

HYPOGLYCEMIA – LOW BLOOD GLUCOSE
(As per Physician/Parent instructions: ____ mmol/L or less)
DO NOT LEAVE STUDENT UNATTENDED

Usual symptoms of Hypoglycemia for my child are:

☐ Shaky	☐ Irritable/Grouchy	☐ Dizzy	☐ Trembling
☐ Blurred Vision	☐ Headache	☐ Hungry	☐ Weak/Fatigue
☐ Pale	☐ Confused	☐ Other _____	

Steps to take for Mild Hypoglycemia (student is responsive)

1. Check blood glucose, give _____grams of fast acting carbohydrate (e.g. ½ cup of juice, 15 skittles)
2. Re-check blood glucose in 15 minutes.
3. If still below 4 mmol/L, repeat steps 1 and 2 until BG is above 4 mmol/L. Give a starchy snack if next meal/snack is more than one (1) hour away.

Steps for Severe Hypoglycemia (student is unresponsive)

1. Place the student on their side in the recovery position.
2. Call 9-1-1. Do not give food or drink (choking hazard). Supervise student until EMS arrives.
3. Contact parent(s)/guardian(s) or emergency contact

HYPERGLYCEMIA — HIGH BLOOD GLOCOSE
(As per Physician/Parent instructions: _____ mmol/L or above)

Usual symptoms of hyperglycemia for my child are:

☐ Extreme Thirst	☐ Frequent Urination	☐ Headache
☐ Hungry	☐ Abdominal Pain	☐ Blurred Vision
☐ Warm, Flushed Skin	☐ Irritability	☐ Other: _____

Steps to take for Mild Hyperglycemia

1. Allow student free use of bathroom
2. Encourage student to drink water only
3. Inform the parent/guardian if BG is above _____

Symptoms of Severe Hyperglycemia (Notify parent(s)/guardian(s) immediately)

☐ Rapid, Shallow Breathing	☐ Vomiting	☐ Fruity Breath

Steps to take for Severe Hyperglycemia

1. If possible, confirm hyperglycemia by testing blood glucose
2. Call parent(s)/guardian(s) or emergency contact

Plan of Care for: _____

HEALTHCARE PROVIDER INFORMATION

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____

Special Instructions/Notes/Prescription Labels: _____

_____

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.

✸This information may remain on file if there are no changes to the student's medical condition.

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

1. _____ 2. _____ 3._____

4._____ 5._____ 6._____

Other Individuals To Be Contacted Regarding Plan Of Care:

Before-School Program ☐Yes ☐No _____

After-School Program ☐Yes ☐No _____

School Bus Driver/Route # (If Applicable) _____

Other: _____

This plan remains in effect for the 20___— 20___ school year without change and will be reviewed on or before: _____ (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).

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

Student: _____ Date:_____
Signature

Principal: _____ Date: _____
Signature