PREVALENT MEDICAL CONDITION DIABETES

PLAN OF CARE

STUDENT INFORMATION		Student Photo
Student Name:		
Student wears Medical-Alert Bracelet YES NO		
Date of Birth	Age:	
Teacher	Grade:	☐ I consent to publicly displaying this photo.

EMERGENCY CONTACTS in ORDER		
Name	Relationship	Phone #
1.		
2.		
3.		
4.		

Has medication been prescribed? Yes No
If yes, the following section must be completed by a physician.

Name of Medication	
Method of Administration	Dosage: Time of Administration:
Additional Information	
Name of Physician (print)	
Phone Number	
Signature	DATE:

Does the student have any other Prevalent Medical Conditions for which there is a Plan of Care? No Yes

If Yes, check all that apply:

- ☐ Anaphylaxis
- ☐ Asthma
- ☐ Concussion
- ☐ Epilepsy/Seizures

TYPE ONE DIABETES SUPPORTS

Names of trained individuals who will provide support with diabetes-related tasks.	
Method of home-school communication	

DAILY MANAGEMENT

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	Recommended time(s) for meals/snacks:____________________
❒ 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.	Parent(s)/Guardian(s) Responsibilities:______________________ ____ School Responsibilities:__________________________________ ____ Student Responsibilities:_________________________________ Special instructions for meal days/ special events:____________ ____

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)

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: ____

A student with special needs may require additional support. Describe below:

NCCSA EMERGENCY PROCEDURES FOR DIABETES	
HYPOGLYCEMIA – LOW BLOOD GLUCOSE **(4 mmol/L or less)** **DO NOT LEAVE STUDENT UNATTENDED**	
TYPICAL SIGNS OF HYPOGLYCEMIA FOR MY CHILD INCLUDE:	☐ 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. 1⁄2 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 the 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** **3. Do not give food or drink (choking hazard).** **4. Supervise the student until emergency medical personnel arrive.** **5. Contact parent(s)/guardian(s) or emergency contact**
HYPERGLYCEMIA — HIGH BLOOD GLUCOSE **(14 MMOL/L OR ABOVE)**	
Usual Signs of HYPERGLYCEMIA for my child include:	☐ 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	☐ Rapid Shallow Breathing ☐ Vomiting ☐ Fruity Breath
Steps to take for SEVERE Hyperglycemia	1. If possible, confirm hyperglycemia by testing blood glucose **NOTIFY PARENTS IMMEDIATELY**

Please review this plan of care with your healthcare provider.		
Name:	Profession ☐ Physician ☐ Nurse practitioner	Medication: Name: Dosage: Frequency:
Special Instructions:		
Signature (where possible):		Date:

INDIVIDUALS with whom THIS PLAN OF CARE WILL BE SHARED

- ☐ **I/we authorize the principal to share the Plan of Care with school staff who are in direct contact with my child.**
- ☐ **I/we authorize the following to also have access to this Plan of Care (check all that apply)**
  - ☐ **Niagara Children's Centre**
  - ☐ **Before and/or After School Program**
  - ☐ **Transportation Provider**
    - ☐ **BUS # __________**

This plan of care remains in effect for the ________ School Year and will be reviewed within the first 30 days of a new school year
If at that time, there are no changes to the student medical history, this information may remain on file.
It is the responsibility of parents to notify the principal if there is a need to change this plan during the school year.

Parent Signature:	Date:
Student Signature:	Date:
Principal Signature:	Date: