Plan of Care:

DIABETES

School Year: 20__- 20__

Student Name	**DOB**	**Gender**	**Student Photo**
Address		**Student #**	
Exceptionality:	**Medic Alert I.D.** **Yes ☐ No ☐**	**OEN#**	
1.			
2.			
3.			
Grade	**Age**	**Teacher(s)**	

EMERGENCY CONTACT (LIST IN PRIORITY)			
NAME:	RELATIONSHIP	MAIN CONTACT #	ALTERNATE #
1.			
2.			
3.			
4.			

(HAVE ABILITY TO ADD MORE CONTACTS)

TYPE 1 DIABETES SUPPORTS

Name of trained individuals who will provide support with diabetes-related tasks:

Designated Staff:_____

LHIN Care Workers(if applicable):_____

Method of home-school communication:_____

Any other medical condition or allergy? _____

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 (6) 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 *Students should be able to check blood glucose anytime, anyplace, respecting their preference for privacy	Target Blood Glucose Range_____ Times to check BG:_____ Contact Parent(s)/Guardian(s) if BG is:_____ Parent(s) Guardian(s) Responsibilities: School Responsibilities:_____ Student Responsibilities:_____ Outside Agency Responsibilities:
Nutrition Breaks ☐student requires supervision during meal times to ensure completion ☐student can independently manage food intake * Reasonable accommodation must be made to allow student to eat all of the	Recommended times for meals/snacks:_____ Parent(s) Guardian(s) Responsibilities_____ School Responsibilities:_____ Student Responsibilities:_____

provided meals and snacks on time. Students should not trade or share food/snacks with other students	Special Instructions for meal days/special events_____ _____ _____ Outside Agency Responsibilities:_____ _____

ROUTINE	ACTION
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/ Guardian ☐ Trained Individual ☐ nurse *All students with Type 1 diabetes use insulin. Some students will require insulin during the school day, typically before meal/ nutrition breaks	**Please complete either A or B:** **A. Injection Delivery:** 1. Student must be able to eat according to daily schedule 2. Student must be able to eat all required food sent by parents 3. Supervision will be required: yes □ no □ 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:_____ _____ Outside Agency Responsibilities _____ Additional Comments _____

	B. Insulin Pump Bolus: 1. Student must be able to eat according to daily schedule 2. Supervision will be required: yes □ no □ 3. Student must be able to eat all required food sent by parents or 4. Student may independently adjust bolus to accommodate amount of food ☐ Before each snack/meal of carbohydrates ☐ Carbohydrate/insulin ratio: _____ Student may unhook pump for a maximum of one hour during intense physical activity yes ☐ no ☐ While disconnected pump will be stored: _____ Parent(s) Guardian(s) Responsibilities_____ _____ School Responsibilities:_____ _____ Student Responsibilities:_____ _____ Outside Agency 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 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
DIABETES MANAGEMENT KIT *Parents must provide, maintain, and refresh supplies. School must ensure this kit is accessible at 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: ☐ Supplies: ☐Blood Glucose meter and strips ☐Lancing device and lancets ☐Glucagon Needle ☐Sharps Disposal Container ☐ For syringe delivery students ☐ Insulin pen/syringe ☐ Insulin ☐ For pump delivery students: Supplies as decided:_____ _____ ☐ Source of fast-acting sugar (e.g. juice, candy glucose tabs) **Fast acting sugars to be stored. Provide specific locations** In classroom:_____ In office:_____ In gym:_____ ☐ Carbohydrate containing snacks ☐ Other (Please list) _____ Location of supplies:_____ Location of kit:_____ Location of Sharps Disposal Container: _____
SPECIAL NEEDS A Student with special considerations may require more assistance than outlined in this plan.	Comments:

ILLNESS

When students with diabetes become ill at school, the parent/guardian/caregiver should be notified immediately so that they can take appropriate action. Nausea and vomiting (flu-like symptoms) and the inability to retain food and fluids are serious situations since food is required to balance the insulin. This can lead to Hypoglycaemia or be the result of hyperglycaemia.

Comments:_____
_____
_____

EXCURSION PROTOCOL

During all trips off school property, the parent/guardian will provide an excursion kit which will consist of:

- ☐ Low kit
- ☐ Pocket emergency card
- ☐ Cell phone (if parent/guardian/caregiver chooses)

EMERGENCY PROCEDURES

DO NOT LEAVE STUDENT UNATTENDED

HYPOGLYCEMIA – LOW BLOOD GLUCOSE (4 mmol/L OR LESS)

- Blood sugars below 4. mm or below 6.mm for 5 years and under
- Student will be allowed extra juice/snacks any time they feel low as per hypoglycaemic plan

Causes:

- Insufficient carbohydrates due to delayed or missed food
- More exercise than usual without a corresponding increase in food
- Too much insulin

Usual Symptoms of **Hypoglycemia** for my child are: (Select all that apply)

☐ Cold/Clammy/Sweaty skin	☐ Shakiness, poor coordination	☐ Quietness
☐ Lack of concentration	☐ Dizziness	☐ Blurred Vision
☐ Reports feeling low	☐ Irritability, Poor behaviour	☐ Weak/Fatigue
☐ Pale	☐ Confused	☐ Hungry

☐ Other:_____

Predicted times/activities common to low blood sugar for my child:

_____

_____

Steps to take for <u>Mild</u> 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 <u>Severe</u> 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 GLUCOSE (14 mmol/L OR ABOVE)

- Blood sugars are 14.0 or above

Causes:

- Too many carbohydrates
- Less than the usual amount of activity
- Not enough insulin
- Illness

Usual Symptoms of **Hyperglycemia** for my child are: (Select all that apply)

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

☐ Other: _____

For pump delivery students: correct with insulin bolus yes ☐ no ☐ N/A ☐

Steps to take for <u>Mild</u> 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 <u>Severe</u> Hyperglycemia (Notify parent(s)/guardian(s) immediately)

☐ Rapid, Shallow Breathing	☐ Vomiting	☐ Fruity Breath

Steps to take for <u>Severe</u> Hyperglycemia

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

Consent for student to carry and self-administer Diabetes medication

We agree that _____,
(student name)

☐can **carry** prescribed medications and delivery devices to manage Diabetes while at school and during school-related activities.

☐can **self-administer** prescribed medications and delivery devices to manage Diabetes while at school and during school-related activities.

☐**requires assistance** with administering prescribed medications and delivery devices to manage Diabetes while at school and during school-related activities.

☐**It is the parent/guardian responsibility to notify the principal if there is a need to change the plan of care during the school year and to inform the school of any change of medication or delivery device**. This medication **cannot** be beyond the expiration date. **This plan remains in effect for the 20__--20__ school year without change and will be reviewed on or before: _____.**

Parent/Guardian Name: _____ Signature: _____ Date: _____

Parent/Guardian Name: _____ Signature: _____ Date: _____

Student Name: _____ Signature: _____ Date: _____

Principal Name: _____ Signature: _____ Date: _____

HEALTHCARE PROVIDER INFORMATION (MANDATORY)

To be included by healthcare professional (I.E.: Medical Doctor, Pharmacist, Nurse, or other clinician working within their scope of practice)

Healthcare Provider's Name:
_____

Profession/Role:
_____

Signature: _____ Date: _____

Special Instructions/Notes/Prescription Labels/Comments:

- 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)