

ST. CLAIR CATHOLIC DISTRICT SCHOOL BOARD

PREVALENT MEDICAL CONDITION — TYPE 1 DIABETES Plan of Care

STUDENT INFORMATION	
Student Name _____	Date Of Birth _____
Ontario Ed. # _____	Age _____
Grade _____	Teacher () _____

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

TYPE 1 DIABETES SUPPORTS
<p>Names of trained individuals who will provide support with diabetes-related tasks: (e.g. designated staff or community care allies.)</p> <hr style="border: 0; border-top: 1px solid black; margin: 10px 0;"/>
<p>Method of home-school communication: _____</p>
<p>Any other medical condition or allergy? _____</p>

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DAILY/ROUTINE TYPE 1 DIABETES MANAGEMENT	
<p>Student is able to manage their diabetes care independently and does not require any special care from the school.</p> <p style="text-align: center;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p><input type="checkbox"/> If Yes, go directly to page five (5) — Emergency Procedures</p>	
ROUTINE	ACTION
<p>BLOOD GLUCOSE MONITORING</p> <p><input type="checkbox"/> Student requires trained individual to check BG/ read meter.</p> <p><input type="checkbox"/> Student needs supervision to check BG/ read meter.</p> <p><input type="checkbox"/> Student can independently check BG/ read meter.</p> <p><input type="checkbox"/> Student has continuous glucose monitor (CGM)</p> <p>* Students should be able to check blood glucose anytime, anyplace, respecting their preference for privacy.</p>	<p>Target Blood Glucose Range _____</p> <p>Time(s) to check BG: _____</p> <p>_____</p> <p>Contact Parent(s)/Guardian(s) if BG is: _____</p> <p>Parent(s)/Guardian(s) Responsibilities: _____</p> <p>_____</p> <p>School Responsibilities: _____</p> <p>_____</p> <p>Student Responsibilities: _____</p>
<p>NUTRITION BREAKS</p> <p><input type="checkbox"/> Student requires supervision during meal times to ensure completion.</p> <p><input type="checkbox"/> Student can independently manage his/her food intake.</p> <p>* 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</p>	<p>Recommended time(s) for meals/snacks: _____</p> <p>Parent(s)/Guardian(s) Responsibilities: _____</p> <p>_____</p> <p>School Responsibilities: _____</p> <p>_____</p> <p>Student Responsibilities: _____</p> <p>Special instructions for meal days/ special events: _____</p> <p>_____</p>

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ROUTINE	ACTION (CONTINUED)
<p>INSULIN</p> <p><input type="checkbox"/> Student does not take insulin at school.</p> <p>Student takes insulin at school by:</p> <p><input type="checkbox"/> Injection <input type="checkbox"/> Pump</p> <p>Insulin is given by:</p> <p><input type="checkbox"/> Student <input type="checkbox"/> Student with supervision <input type="checkbox"/> Parent(s)/Guardian(s) <input type="checkbox"/> Trained Individual</p> <p>* All students with Type 1 diabetes use insulin. Some students will require insulin during the school day, typically before meal/nutrition breaks.</p>	<p>Location of insulin: _____</p> <p>_____</p> <p>Required times for insulin: _____</p> <p><input type="checkbox"/> Before school: <input type="checkbox"/> Morning Break:</p> <p><input type="checkbox"/> Lunch Break: <input type="checkbox"/> Afternoon Break:</p> <p><input type="checkbox"/> Other (Specify): _____</p> <p>Parent(s)/Guardian(s) responsibilities: _____</p> <p>School Responsibilities: _____</p> <p>Student Responsibilities: _____</p> <p>Additional Comments: _____</p>
<p>ACTIVITY PLAN</p> <p>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.</p>	<p>Please indicate what this student must do prior to physical activity to help prevent low blood sugar:</p> <p>1. Before activity: _____</p> <p>2. During activity: _____</p> <p>3. After activity: _____</p> <p>Parent(s)/Guardian(s) Responsibilities: _____</p> <p>School Responsibilities: _____</p> <p>Student Responsibilities: _____</p> <p>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)</p>

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ROUTINE	ACTION (CONTINUED)
<p>DIABETES MANAGEMENT KIT</p> <p>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.</p>	<p>Kits will be available in different locations but will include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Blood Glucose meter, BG test strips, and lancets <input type="checkbox"/> Insulin and insulin pen and supplies. <input type="checkbox"/> Source of fast-acting sugar (e.g. juice, candy, glucose tabs.) <input type="checkbox"/> Carbohydrate containing snacks <input type="checkbox"/> Other (Please list) _____ <hr style="border: 0.5px solid black;"/> <p>Location of Kit:</p>
<p>SPECIAL NEEDS</p> <p>A student with special considerations may require more assistance than outlined in this plan.</p>	<p>Comments:</p>

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EMERGENCY PROCEDURES

HYPOGLYCEMIA – LOW BLOOD GLUCOSE (4 mmol/L or less)

DO NOT LEAVE STUDENT UNATTENDED

Usual symptoms of Hypoglycemia for my child are:

- | | | | |
|---|--|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Shaky | <input type="checkbox"/> Irritable/Grouchy | <input type="checkbox"/> Dizzy | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Headache | <input type="checkbox"/> Hungry | <input type="checkbox"/> Weak/Fatigue |
| <input type="checkbox"/> Pale | <input type="checkbox"/> Confused | <input type="checkbox"/> 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 (14 MMOL/L OR ABOVE)

Usual symptoms of hyperglycemia for my child are:

- | | | |
|---|---|---|
| <input type="checkbox"/> Extreme Thirst | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Hungry | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> Warm, Flushed Skin | <input type="checkbox"/> Irritability | <input type="checkbox"/> 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)

- | | | |
|---|-----------------------------------|--|
| <input type="checkbox"/> Rapid, Shallow Breathing | <input type="checkbox"/> Vomiting | <input type="checkbox"/> 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

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HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

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