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| **PREVALENT MEDICAL CONDITION — TYPE 1 DIABETES****Plan of Care** |
| **STUDENT INFORMATION** |
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| Student Name       | Date Of Birth       |
| Ontario Ed. #       | Age       |
| Grade       | Teacher(s)       |

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

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| **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?       |

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|  **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 |

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| **ROUTINE** | **ACTION** |
| **BLOOD GLUCOSE MONITORING** | Target Blood Glucose Range:       |
| [ ]  Student require trained individual to check BG/read meter. | Time (s) to check BG:       |
| [ ]  Student needs supervision to check BG/read meter.[ ]  Student can independently check BG/read meter. | Contact Parent(s)/Guardian (s) if BG is:      Parent(s)/Guardians(s) Responsibilities:       |
| [ ]  Student has continuous glucose monitor (CGM) | School Responsibilities:       |
| **\*** Students should be able to check blood glucose anytime, anyplace, respecting their preference for privacy. | Student Responsibilities:       |
| **NUTRITION BREAKS** | Recommended time(s) for meals/snacks:      |
| **[ ]** Student requires supervision during meal times to ensure completion. | Parent(s)/Guardian(s) Responsibilities:       |
| **[ ]** Student can independently manage his/her food intake. | School Responsibilities:       |
| **\*** 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. | Student Responsibilities:      Special instructions for meal days/special events:       |

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| **ROUTINE** | **ACTION (CONTINUED)** |
| **INSULIN****[ ]** Student does not take insulin at school.[ ]  Students 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)  |

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| **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:      |

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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:[ ]  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 emergency medical personnel arrives.
3. Contact parent(s)/guardian(s) or emergency contact.
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| **HYPERGLYCEMIA — HIGH BLOOD GLOCOSE****(14 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 Hyperglycemia1. 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 BreathSteps to take for Severe Hyperglycemia1. If possible, confirm hyperglycemia by testing blood glucose
2. Call parent(s)/guardian(s) or emergency contact.
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| **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. |

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| **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:** Click or tap to enter a date. (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 |  |  |