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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. |
| **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 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. |

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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 | | | | | |  |  | |