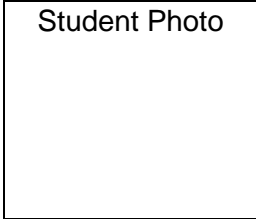




DIABETES TYPE 1 – Plan of Care

518-3



Name: _____ Date of Birth: _____

Grade: _____ Teacher: _____

Student's Approximate Weight: _____

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

TYPE 1 DIABETES SUPPORTS

Names of trained individuals who will provide support with diabetes-related tasks: (e.g. LHIN support) _____

Method of home-school communication: _____

Any other life-threatening medical condition or allergy? _____

Staff who have been trained to administer GLUCAGON (if applicable): _____

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 If Yes, go to page 3.

No If No, see information below and page 2 for student supports.

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: _____

Location of insulin: _____

Additional Comments: _____

DAILY SCHEDULE OF ROUTINE DIABETES-RELATED TASKS

TIME	MEAL/SNACK	BG* CHECK	INSULIN	COMMENTS

LEGEND: A- Assistance Required; S- Supervision needed; I – Independent. *BG= Blood glucose (sugar)

PHYSICAL ACTIVITY

ROUTINE	MANAGEMENT
<p>BG meter and fast-acting sugar should ALWAYS be accessible during physical activities.</p> <p>Risk of low blood sugar increases during/after physical activity.</p> <p>The student may need extra BG check(s) and/or extra food.</p> <p><input type="checkbox"/> Student can make decisions about physical activities independently</p> <p><input type="checkbox"/> Student needs supervision/guidance around physical activity</p>	<p>Notify parents whenever special activities are planned (for example, Terry Fox run, track and field day, field trip or other active event)</p> <p><input type="checkbox"/> No action needed before activity</p> <p><input type="checkbox"/> Check blood sugar before regular physical activity class</p> <p><input type="checkbox"/> Check blood sugar before unplanned activity</p> <p>Comments: _____</p> <hr/> <p>If blood sugar is:</p> <ul style="list-style-type: none"> Under 4 mmol/L, treat for low blood sugar Between 4 mmol/L and _____, give a snack before activity Above _____, no snack is needed before activity <p>For students on a pump:</p> <p><input type="checkbox"/> No specific pump adjustments needed</p> <p><input type="checkbox"/> Suspend/disconnect pump for activity. Store _____</p> <p><input type="checkbox"/> Other: _____</p>

SPECIAL CONSIDERATIONS

SUPPLIES / EMERGENCY KITS

Schools ensure kit is accessible at all times (class, gym, field trips, fire drills, etc.). Advise parent/guardian when running low on supplies. Parent/Guardian must maintain/refresh supplies.

Contents	With Student	Classroom	Office	Other location(s)
Blood glucose meter, test strips, lancets				
Fast-acting sugar (juice, glucose tabs, candy) for low blood sugar				
Carbohydrate snack(s)				
Glucagon (expiry date: ____ / ____)				
Sharps disposal container				
Ketone strips/meter				
Insulin pen, pen needles, insulin (in case of pump failure)				
Extra batteries for meter				
Parent/guardian names and contact numbers (for trips)				

HEALTHCARE PROVIDER INFORMATION

I hereby agree with the diagnosis of this student, the medication, and the above plan.

Health Care Provider (please print) Signature Date

AUTHORIZATION / PLAN REVIEW

This Plan remains in effect for the 20__ - 20__ school year. (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)/Student (if age 18+)

Signature Date

_____ (Parent Initial) I authorize the sharing of this plan with principals, teachers, support staff, volunteers, bus operators and drivers, and other adults as appropriate.

_____ (Parent Initial) I authorize the sharing of signs and symptoms of this medical condition with other students.

Authorization for the collection of this information is in the Education Act. The purpose is to collect and share medical information and to administer proper medical care in the event of an emergency or life-threatening situation. The original form and all copies will be retained and securely destroyed in accordance with the board's Records Management Manual and Policy 316. Contact person concerning this collection is the school principal.

EMERGENCY PROCEDURES - DO NOT LEAVE STUDENT UNATTENDED

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

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:

_____ glucose tablets _____ ml juice _____ Skittles _____ Rockets (roll candy) _____
(other)

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.
4. Give a starchy snack if next meal/snack is more than one (1) hour away.

Steps to take for Severe Hypoglycemia (student is unresponsive or unable to swallow)

1. Place the student on their side in the recovery position. 
2. Call 911. Do not give food or drink (choking hazard). Supervise student until EMS arrives.
3. Contact parent(s)/guardian(s) or emergency contact.

Glucagon Administration: If a glucagon kit (not expired) is available, and training has been provided to the school staff:

- Call 911
- Trained staff perform glucagon injection
- Contact parents and/or other emergency contacts

HYPERGLYCEMIA — HIGH BLOOD GLUCOSE (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/guardian/emergency contact immediately.