



INDIVIDUAL DIABETES PLAN OF CARE		
STUDENT INFORMATION		
Student Name _____	Date of Birth _____	Student Colour Photo
Grade _____	Teacher(s) _____	

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> <p>_____</p>
<p>Method of home-school communication: _____</p>
<p>Any other medical condition or allergy? _____</p>

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

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.

Student has continuous glucose monitor (CGM)

* Students should be able to check blood glucose anytime, anyplace, respecting their preference for privacy.

Target Blood Glucose Range _____

Time(s) to check BG: _____

Contact Parent(s)/Guardian(s) if BG is: _____

Parent(s)/Guardian(s) Responsibilities: _____

School Responsibilities: _____

Student Responsibilities: _____

NUTRITION BREAKS

Student requires supervision during meal times to ensure completion.

Student can independently manage his/her food intake.

* 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.

Recommended time(s) for meals/snacks: _____

Parent(s)/Guardian(s) Responsibilities: _____

School Responsibilities: _____

Student Responsibilities: _____

Special instructions for meal days/ special events: _____

ROUTINE	ACTION (CONTINUED)
<p>DIABETES MANAGEMENT KIT</p> <p>Parents/Guardians/Adult Student 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/guardians/adult students 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) _____ <p>_____</p> <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>

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

Refer to Appendix J for the Board Policy concerning Diabetes

HYPERGLYCEMIA — HIGH BLOOD GLOCOSE

(14 MMOL/L OR ABOVE)

Usual symptoms of hyperglycemia for my child/myself 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

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**

		Yes (Please Initial for each)	No (Please Initial for each)
We, the Parents/Guardians/ Adult Student request the posting of this Individual Plan of Care in the:	School Staff Room		
	Elementary Homeroom Classroom		
	School Main Office		
We the Parents/Guardians/Adult Student request the sharing of this plan with individuals which include, but are not limited to classroom teachers, occasional teachers, itinerant teachers, educational assistants, coaches, other school staff, and school bus drivers.			
We the Parents/Guardians/ Adult Student request the sharing of information on signs and symptoms of Diabetes with students in the classroom.			
We, the Parents/Guardians request the sharing of this Individual Plan of Care with the Before and After-School Program.			

TRANSPORTATION

School Bus Driver/Route # (If Applicable) New Plan of Care Updated Plan of Care

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)/adult student'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:

Adult Student:

Date:

Principal:

Date: