

**PREVALENT MEDICAL CONDITION — TYPE 1 DIABETES  
PLAN OF CARE**

**STUDENT INFORMATION**

Student Photo

Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Ontario Ed # \_\_\_\_\_ Age \_\_\_\_\_

Grade \_\_\_\_\_ HR \_\_\_\_\_ Teacher \_\_\_\_\_

**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. designated staff or community care allies.)

\_\_\_\_\_

\_\_\_\_\_

Method of home-school communication: \_\_\_\_\_

Any other medical condition or allergy? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Plan of Care for: \_\_\_\_\_

**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
<p><b>BLOOD GLUCOSE MONITORING</b></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>_____</p> <p>Parent(s)/Guardian(s) Responsibilities: _____</p> <p>_____</p> <p>School Responsibilities: _____</p> <p>_____</p> <p>Student Responsibilities: _____</p>
<p><b>NUTRITION BREAKS</b></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>

Plan of Care for: \_\_\_\_\_

ROUTINE	ACTION
<p><b>INSULIN</b></p> <p><input type="checkbox"/> Student does not take insulin at school.</p> <p><input type="checkbox"/> Student takes insulin at school by:</p> <p style="padding-left: 40px;"><input type="checkbox"/> Injection</p> <p style="padding-left: 40px;"><input type="checkbox"/> Pump</p> <p><input type="checkbox"/> Insulin is given by:</p> <p style="padding-left: 40px;"><input type="checkbox"/> Student</p> <p style="padding-left: 40px;"><input type="checkbox"/> Student with Supervision</p> <p style="padding-left: 40px;"><input type="checkbox"/> Parent(s)/Guardian(s)</p> <p style="padding-left: 40px;"><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>_____</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><b>ACTIVITY PLAN</b></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>_____</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>

Plan of Care for: \_\_\_\_\_

ROUTINE	ACTION (CONTINUED)
<p><b>DIABETES MANAGEMENT KIT</b></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"> <li><input type="checkbox"/> Blood Glucose meter, BG test strips, and lancets</li> <li><input type="checkbox"/> Insulin and insulin pen and supplies.</li> <li><input type="checkbox"/> Source of fast-acting sugar (e.g. juice, candy, glucose tabs)</li> <li><input type="checkbox"/> Carbohydrate containing snacks</li> <li><input type="checkbox"/> Other (Please list): _____</li> </ul> <p>_____</p> <p>Location of Kit: _____</p> <p>_____</p>
<p><b>SPECIAL NEEDS</b></p> <p>A student with special considerations may require more assistance than outlined in this plan.</p>	<p>Comments:</p>

Plan of Care for: \_\_\_\_\_

### EMERGENCY PROCEDURES

#### HYPOGLYCEMIA – LOW BLOOD GLUCOSE

(As per Physician/Parent instructions: \_\_\_\_\_ 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

(As per Physician/Parent instructions: \_\_\_\_\_ 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

Plan of Care for: \_\_\_\_\_

**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.

**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