JAMES BAY LOWLANDS SECONDARY SCHOOL BOARD

PREVALENT MEDICAL CONDITION — DIABETES PLAN OF CARE

STUDENT INFORMATION Student Photo

Student Name _____ Date of Birth _____

Ontario Ed. # _____ Age _____

Teacher(s) _____ Grade _____

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	HOME PHONE	CELL 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?

_____

Student is able to manage his or her diabetes care independently and does not require any special care from the school.

□ If Yes, go directly to FORM ADMIN 320-B-03 Emergency Procedures

□ No

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) • Note: 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 if BG is: _____ Parent Responsibilities: School Responsibilities: Student Responsibilities:
NUTRITION BREAKS □ Student requires supervision during meal times to ensure completion. □ Student can independently manage his/her food intake. * Note: 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 Responsibilities: School Responsibilities: Student Responsibilities: Special Instructions for Special Events:

ROUTINE	ACTION [CONTINUED]
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 □ Trained Individual *Note: 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 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 the student's 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 Responsibilities: School Responsibilities: Student Responsibilities: For special events, notify parent in advance so that appropriate adjustments or arrangements can be made. (e.g. extracurricular, field trip)

ROUTINE	ACTION [CONTINUED]
DIABETES MANAGEMENT KIT Parents must provide, maintain, and refresh supplies. The school must ensure that this kit is accessible at all times. (E.g. field trips, fire drills, lockdowns). The school must 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:

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 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 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 or emergency contact.

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Therapist, or Certified Diabetes 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.
*Note: 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 the 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 parents' responsibility to notify the principal if there is a need to change the plan of care during the school year).

Parent: _____ Date: _____
Signature
Student: _____ Date: _____
Signature
Principal: _____ Date: _____
Signature