Dufferin-Peel Catholic District School Board

Plan of Care – Prevalent Medical Condition

GF 514.10D

Type 1 Diabetes

STUDENT SPECIFIC

Student Name: _____ Date of Birth: _____ Age: _____

OEN Number: _____ Teacher: _____ Grade: _____

Medical Alert ID: Yes ☐ No ☐ (for high schools, indicate Semester 1 Homeroom Teacher)

Any other medical condition or allergy? _____

Insert Student Photo

Emergency Contact Information:

Name:	Relationship:	Contact Numbers:

Type 1 Diabetes Supports

Names of trained individuals who will provide support with diabetes-related tasks:

Name:	Position:	Role:

Daily Routine Type 1 Diabetes Management

Target Blood Glucose Range: _____ **Time(s) to check Blood Glucose: _____ and _____**

Contact parent(s) / guardian(s) if BG is: _____

Location of insulin: _____ **Required times for insulin: _____**

- ✓ Parents MUST provide, maintain, and refresh supplies and school must ensure this kit is accessible at all times.
- ✓ Student should be able to check blood glucose anytime, anyplace, respecting their preference for privacy.
- ✓ Reasonable accommodation must be made to all student to eat all of the provided meals and snacks on time. Student should not trade or share food/snacks with other students.
- ✓ All students with Type 1 diabetes use insulin. Some students will require insulin during the school day, typically before meal/nutrition breaks.
- ✓ 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.

Student is able to manage their diabetes care INDEPENDENTLY and does NOT require any special care from the school.

Yes ☐ If YES, go directly to page 4 – Emergency Procedures.

No ☐ If NO, complete the following sections.

Blood Glucose Monitoring:	**Insulin:**
☐ Student requires trained individual to check Blood Glucose (BG) /read meter ☐ Student needs supervision to check BG /read meter. ☐ Student can independently check BG/read meter. ☐ Student has continuous glucose monitor (CGM).	☐ Student does not take insulin at school. ☐ Student takes insulin at school by: injection or pump (circle appropriate) ☐ Insulin is given by: ☐ student ☐ student with supervision ☐ parent(s)/guardian(s) ☐ trained individual
Nutrition Breaks:	**Activity Plan:**
☐ Student requires supervision during meal times to ensure completion. Recommended times: _____ ☐ Student can independently manage his/her food intake.	☐ Student must do the following prior to physical activity to help prevent low blood sugar. Before: _____ During: _____ After: _____
Diabetes Management Kit will include:	**Other Considerations:**
☐ Blood Glucose meter ☐ BG test strips ☐ Lancets ☐ Insulin and insulin pen and supplies ☐ Source of fast-acting sugar (e.g. juice, candy) ☐ Carbohydrate containing snacks ☐ Other: _____	

Name of Medication: _____ Dosage: _____ Expiry Date: _____ Time to administer: _____

Special accommodations to be considered (if applicable): _____

Possible sign effects: _____

Additional instructions (e.g. storage of medication): _____

Disposal of Medication: _____

Healthcare Provider's Name: _____

Profession / Role: _____

Signature: _____ Date: _____

(Health Care Provider)

☐ Diabetes Management Kit will be stored in the office. This is the primary and only kit. ☐ This is the secondary. ☐

☐ Student **will carry** their Diabetes Management Kit **at all times**.

☐ If applicable, Diabetes Management Kit will be stored in the student's locker. Locker # _____

Administrative / Plan Review

Individuals with whom this Plan of Care is to be shared:

☐ Principal or Principal Designate ☐ Teacher-in-Charge ☐ Administrative Assistant (s)

☐ Classroom Teacher(s) ☐ Planning Time Teacher(s) ☐ Resource Teacher(s) / Support Services

☐ Student Monitors/ Volunteers ☐ Occasional Teachers

Other individuals to be contacted regarding Plan of Care:

☐ PLASP / Daycare ☐ Transportation ☐ Other: _____

As the parent of _____, I have been an active participant in supporting the management of their child's medical condition(s) while he/she is in school.

☐ **Teachers and Principals and other school staff are not health professionals and have no more information about the medical condition of my child than that which has been provided to them. They are not experts in recognizing the symptoms of my child's medical condition or in treating it. School Administration and/or staff do NOT administer the glucagon syringe injections. If an Emergency Glucagon Kit is provided by the parent/guardian, it will be made available to emergency personnel (EMS) to be used as appropriate.**

☐ I have educated my child about his/her medical condition.

☐ I have encouraged my child to self-manage and self-advocate.

☐ I give consent to share information on signs and symptoms with other students (e.g. classmates).

☐ I have informed the school of my child's medical condition(s) and will communicate any changes or updates.

This plan remains in effect for the _____ school year without change and will be reviewed annually.

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 – if applicable)

Principal: _____ ***Date:*** _____
(signature)

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	☐ Trembling
☐ Blurred vision	☐ Headache	☐ Weak/Fatigue
☐ Pale	☐ Confused	☐ Other: _____
☐ Dizzy	☐ Hungry	

Actions to take for MILD HYPOGLYCEMIA (student is RESPONSIVE):

Step 1: Check blood glucose and give _____ grams of fast-acting carbohydrate (e.g. ½ cup of juice)
Step 2: Re-check blood glucose in 15 minutes.
Step 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 1 hour away.

Actions to take for SEVERE HYPOGLYCEMIA (student is UNRESPONSIVE):

Step 1: Place the student on their side in the recovery position.
Step 2: Call 9-1-1. Do not give food or drink (choking hazard). Supervise student until EMS arrives.
Step 3: Contact parent(s)/guardian(s) or emergency contact.

School Administration and/or staff do NOT administer the glucagon syringe injections. If an Emergency Glucagon Kit is provided by the parent/guardian, it will be made available to emergency personnel (EMS) to be used as appropriate.

HYPERGLYCEMIA – HIGH BLOOD GLUCOSE (14 MMOL/L OR MORE)

Usual symptoms of Hyperglycemia for my child are:

☐ Extreme thirst	☐ Irritability
☐ Hungry	☐ Headache
☐ Warm, flushed skin	☐ Blurred Vision
☐ Frequent urination	☐ Other:_____
☐ Abdominal Pain	

Actions to take for MILD HYPERGLYCEMIA:

Step 1: Allow student free use of bathroom.
Step 2: Encourage student to drink water ONLY.
Step 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

Actions to take for SEVERE HYPOGLYCEMIA (student is UNRESPONSIVE):

Step 1: If possible, confirm hyperglycemia by testing blood glucose.
Step 2: Contact parent(s)/guardian(s) or emergency contact.