Halton District School Board

DIABETES PLAN OF CARE

for

Student Photo

_____
Student Name **GRADE/CLASS/ROOM**

Teacher(s): _____

DIABETES SUPPORTS

School Care Team (min 2 staff): _____

Method of home – school communication: _____

Any other medical condition or allergy? _____

SAFE STORAGE:

A) INSULIN

☐ Student requires insulin at school by injection. Insulin and necessary equipment is located:

_____

B) DIABETES MANAGEMENT KIT

Student will carry or have readily accessible at all times their Diabetes Management Kit. The Diabetes Management Kit is kept in the student's:

☐ Backpack ☐ Classroom Other:

Additional Diabetes Management kit is also located:

DAILY/ROUTINE TYPE 1 MANAGEMENT

ROUTINE	ACTION
BLOOD GLUCOSE MONITORING	
☐ Student requires trained individual to check BG/read meter	Target Blood Glucose Range _____
☐ Student needs supervision to check BG / read meter	Time(s) to check BG
☐ Student can independently check BG / read meter	Contact Parent(s) / Guardian(s) if BG is:
☐ Student has continuous glucose monitor (CGM)	Parent(s) / Guardian(s) Responsibilities:

✹Students should be able to check blood glucose anytime, anyplace, respecting their preference for privacy	School Care Team Responsibilities: Student Responsibilities:
NUTRITION BREAKS ☐ Student requires supervision during meal times to ensure completion ☐ Student can independently manage their food intake ✹Students should be able to check blood glucose anytime, anyplace, respecting their preference for privacy	Recommended time(s) for meals/snacks: Parent(s) / Guardian(s) Responsibilities: School Care Team Responsibilities: Student Responsibilities: Special instructions for meal days/special events:
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 : _____ ✹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 ☐ Nutrition Break #1 ☐ Nutrition Break #2 ☐ Lunch Other (Specify) Parent(s) / Guardian(s) Responsibilities: School Care Team Responsibilities: Student Responsibilities:
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	Please indicate what this student must do prior to physical activity to help prevent low blood sugar: 1. Before activity: 2. During activity:

must always be within student's reach. ☐ Student requires supervision pre- / post –activity to ensure completion ☐ Student can independently manage their food intake	3. After activity: Parent(s) / Guardian(s) Responsibilities: School Care Team Responsibilities: Student Responsibilities: For special events, notify parent(s)/guardian(s) in advance so that appropriate adjustments or arrangements can be made (e.g. co-curricular activities)
DIABETES MANAGEMENT KIT Parents must provide, maintain, and refresh supplies. This kit must be with the student and accessible at all times. Additional kits may be provided to the school to store in key locations.	Kits 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(s):
SPECIAL NEEDS A student with special considerations may require more assistance than outlined in plan.	Comments:

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	**RELATIONSHIP**	**DAYTIME PHONE**	**ALTERNATE PHONE**

EMERGENCY PROCEDURES

HYPOGLYCEMIA – LOW BLOOD GLUCOSE (4mmol/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, and respond immediately by giving _____ gms of fast acting carbohydrate (e.g. ½ cup of juice, 15 skittles).
2. Contact the parent(s)/guardian(s) and update throughout steps 3 – 6.
3. Re-check blood glucose in 15 minutes.
4. if still below 4mmol/L repeat steps 1 and 2 until BG is above 4mmol/L. Give a starchy snack if next meal/snack is more than one (1) hour away.
5. Ensure the student is supervised until their BG has increased and is stabilized as indicated on their Diabetes Plan of Care.
6. Document the details on the Medical Incident Record.

Steps to take 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).
3. Contact parent(s)/guardian(s) or emergency contact.
4. Supervise student until EMS arrives.
5. Transport student to hospital by ambulance and/or follow the direction of medical personnel.

HYPERGLYCEMIA – HIGH BLOOD GLUCOSE (14MMOL/l OR HIGHER)

Usual symptoms of **HYPERGLYCEMIA** for my child are:

☐ extreme thirst	☐ frequent urination	☐ headache	
☐ hungry	☐ abdonminal pain	☐ blurred vision	
☐ warm, flushed skin	☐ irritability	other _____	

Symptoms of SEVERE HYPERGLYCEMIA (Notify parent(s)/guardian(s) IMMEDIATELY)

☐ rapid, shallow breathing	☐ vomiting	☐ fruity breath

Steps to take for MILD to SEVERE HYPERGLYCEMIA:

1. Allow student free use of bathroom.
2. Encourage student to drink water only.
3. Inform the parent(s)/guardian(s) if BG is above _____ mmol/L as noted in Diabetes Plan of Care.
4. Document details on the Medical Incident Record.

AUTHORIZATION / PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

(Please select with whom this plan is to be shared)

- ☐ school staff
- ☐ classmates
- ☐ transportation provider
- ☐ lunchroom supervisor
- ☐ relevant occasional staff
- ☐ relevant volunteers
- ☐ before and/or after care
- ☐ post copy
- ☐ food service provider(secondary only)
- other

☐ Authorization for Self-Administration Prescribed Medication by Student Form is completed. NOTE: this form is not required for student using an insulin pump.

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).

I/we further hereby release the Halton District School Board, its employees and agents from any liability for loss, damage, illness or injury, howsoever caused to my/our child's person or property, or to me/us as a consequence, arising from the administration or a failure to administer, correctly or at all, the actions detailed in this Plan of Care.

Parent / Guardian: _____ Student: _____

SIGNATURE* SIGNATURE

Principal or designate: _____ Date: _____

SIGNATURE

*If the student is 18 years and over, a parent signature may not be required.