APPENDIX C: PLAN OF CARE — DIABETES

STUDENT INFORMATION

School _____ Age _____ Homeroom Teacher _____ Student Name _____

PLAN OF CARE — DIABETES

STUDENT INFORMATION

Student Name _____ Date Of Birth _____

Ontario Ed. # _____ Age _____

Grade _____ Teacher(s)_____

Student Photo (optional)

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

Has an emergency rescue medication been prescribed? ❒ Yes ❒ No

If yes, attach the rescue medication plan, healthcare providers' orders and authorization from the student's parent(s)/guardian(s) for a trained person to administer the medication.

NOTE: Rescue medication training for the prescribed rescue medication and route of administration must be done in collaboration with a regulated healthcare professional.

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? _____

APPENDIX C: PLAN OF CARE — DIABETES

STUDENT INFORMATION

School	Age	Homeroom Teacher	Student Name

DAILY/ROUTINE 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 their 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: _____

APPENDIX C: PLAN OF CARE — DIABETES

STUDENT INFORMATION

School _____ Age _____ Homeroom Teacher _____ Student Name _____

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(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: ❒ Morning Break: ❒ Lunch Break: ❒ Afternoon Break: ❒ Other (Specify): _____ Parent(s)/Guardian(s) 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 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(s)/Guardian(s) Responsibilities: _____ School Responsibilities: _____ Student Responsibilities: _____ 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)

APPENDIX C: PLAN OF CARE — DIABETES

STUDENT INFORMATION

School _____ Age _____ Homeroom Teacher _____ Student Name _____

ROUTINE	ACTION (CONTINUED)
DIABETES MANAGEMENT KIT Parents/guardians 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 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:

APPENDIX C: PLAN OF CARE — DIABETES

STUDENT INFORMATION

School _____ Age _____ Homeroom Teacher _____ Student Name _____

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). If prescribed, administer rescue medication as directed by the healthcare provider. Supervise student until emergency medical personnel arrives.
3. Contact parent(s)/guardian(s) 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(s)/guardian(s) 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(s)/guardian(s) or emergency contact

APPENDIX C: PLAN OF CARE — DIABETES

STUDENT INFORMATION

School _____ Age _____ Homeroom Teacher _____ Student Name _____

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 (POC) IS TO BE SHARED:
Note: Only individuals involved in the daily/routine management require the entire Plan of Care. All others will receive Emergency Procedures Section only.

Please select one of the following:

☐ DSBN Teaching and Support Staff, Niagara Student Transportation Services and food service providers.

☐ Only those listed below: _____

_____

_____

_____

Parent(s)/Guardian(s): _____ Date: _____
Signature

Student: _____ Date: _____
Signature

Principal: _____ Date: _____
Signature