

## 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?

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### 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
<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>Contact Parent(s)/Guardian(s) if BG is:</p> <p>Parent(s)/Guardian(s) Responsibilities:</p> <p>School Responsibilities:</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 their 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>School Responsibilities:</p> <p>Student Responsibilities:</p> <p>Special instructions for meal days/ special events:</p>

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ROUTINE	ACTION (CONTINUED)
<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="margin-left: 20px;"><input type="checkbox"/> Injection</p> <p style="margin-left: 20px;"><input type="checkbox"/> Pump</p> <p><input type="checkbox"/> Insulin is given by:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Student</p> <p style="margin-left: 20px;"><input type="checkbox"/> Student with supervision</p> <p style="margin-left: 20px;"><input type="checkbox"/> Parent(s)/Guardian(s)</p> <p style="margin-left: 20px;"><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>Required times for insulin:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Before school:                      <input type="checkbox"/> Morning Break:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Lunch Break:                              <input type="checkbox"/> Afternoon Break:</p> <p style="margin-left: 20px;"><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 student's reach.</p>	<p>Please indicate what this student must do prior to physical activity to help prevent low blood sugar:</p> <ol style="list-style-type: none"> <li>1. Before activity:</li> <li>2. During activity:</li> <li>3. After activity:</li> </ol> <p>Parent(s)/Guardian(s) Responsibilities:</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>

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ROUTINE	ACTION (CONTINUED)
<p><b>DIABETES MANAGEMENT KIT</b></p> <p>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.</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>Location of Kit:</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>

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### EMERGENCY PROCEDURES

#### HYPOGLYCEMIA – LOW BLOOD GLUCOSE

(4 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). 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:

- |   |   |   |
|---|---|---|
| <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

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### 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:

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

Only those listed below: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent(s)/Guardian(s): \_\_\_\_\_

Signature

Date: \_\_\_\_\_

Student: \_\_\_\_\_

Signature

Date: \_\_\_\_\_

Principal: \_\_\_\_\_

Signature

Date: \_\_\_\_\_

Personal information and personal health information on this form is collected, used and disclosed in accordance with the Education Act, R.S.O. 1990, c.E.2, as amended, the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990, c.M. 56, as amended and the Personal Health Information Protection Act, 2004, c.3 Sched. A., as amended and will be used for the purpose of providing student health information for the Plan of Care and any similar or related purpose(s). Questions about this collection, use and disclosure should be directed to the Freedom of Information Coordinator, District School Board of Niagara, 191 Carlton Street, St. Catharines, ON L2R 7P4 905-641-1550