

## 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.			

### 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>_____</p> <p>Contact Parent(s)/Guardian(s) if BG is: _____</p> <p>Parent(s)/Guardian(s) Responsibilities: _____</p> <p>_____</p> <p>School Responsibilities: _____</p> <p>_____</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 his/her 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>_____</p> <p>Required times for insulin: _____</p> <p><input type="checkbox"/> Before school: _____ <input type="checkbox"/> Morning Break: _____</p> <p><input type="checkbox"/> Lunch Break: _____ <input type="checkbox"/> Afternoon Break: _____</p> <p><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 students' reach.</p>	<p>Please indicate what this student must do prior to physical activity to help prevent low blood sugar:</p> <p>1. Before activity: _____</p> <p>2. During activity: _____</p> <p>3. After activity: _____</p> <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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Homeroom Teacher \_\_\_\_\_

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ROUTINE	ACTION (CONTINUED)
<p><b>DIABETES MANAGEMENT KIT</b></p> <p>Parents 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 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). 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: \_\_\_\_\_