



## TYPE 1 DIABETES HEALTH CARE PLAN

### STUDENT INFORMATION

Student Name \_\_\_\_\_ Date Of Birth \_\_\_\_\_

Age \_\_\_\_\_

Grade \_\_\_\_\_ Teacher(s) \_\_\_\_\_

Student Photo (optional)

### 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 EMS 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

### 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? \_\_\_\_\_

## DAILY/ROUTINE TYPE 1 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>_____</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>

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="padding-left: 20px;"><input type="checkbox"/> Injection</p> <p style="padding-left: 20px;"><input type="checkbox"/> Pump</p> <p><input type="checkbox"/> Insulin is given by:</p> <p style="padding-left: 20px;"><input type="checkbox"/> Student</p> <p style="padding-left: 20px;"><input type="checkbox"/> Student with supervision</p> <p style="padding-left: 20px;"><input type="checkbox"/> Parent(s)/Guardian(s)</p> <p style="padding-left: 20px;"><input type="checkbox"/> Third Party Health Care Provider</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>

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>_____</p> <p>Location of Kit: _____</p> <p>_____</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>

Storage and location of spare medication and other supplies if applicable:

Disposal of unused medication and medical supplies if applicable (supply and disposal of unused medication and/or medical supplies are facilitated by the family):

### AUTHORIZATION/PLAN REVIEW

#### INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

Other Individuals To Be Contacted Regarding Plan Of Care:

Before-School Program  Yes  No

After-School Program  Yes  No

School Bus Driver/Route # (If Applicable) \_\_\_\_\_

Other: \_\_\_\_\_

**This plan remains in effect for the 20\_\_— 20\_\_ school year without change and will be reviewed on or before: \_\_\_\_\_ unless otherwise notified by parents of need to revisit the Plan. (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 hereby request that the York Region District School Board, its employees or agents, as outlined, administer the above procedure to my/our child. The York Region District School Board employees are expected to support the student's daily or routine management, and respond to medical incidents and medical emergencies that occur during school, as outlined in board policies and procedures. Parent(s)/guardians and students acknowledge that the employees of the York Region District School Board, who will administer the related procedures, are not medically trained. At all times it remains the responsibility of the parent(s)/guardians to ensure that clear instructions and current physician's orders are provided to the principal.

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

Student: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature

Principal: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature

Authorization for the collection of this information is in accordance with the *Education Act*, the *Municipal Freedom of Information and Protection of Privacy Act*, and the *Personal Health Information Protection Act*, as amended and applicable. The purpose is to collect and share medical information and to administer proper medical care in the event of an emergency or life-threatening situation. Users of this information include but are not limited to principals, teachers, support staff, volunteers, and bus drivers. This form will be kept for a minimum period of one calendar year. Contact person concerning this collection is the school principal.

Distribution: Original: Secure location accessible by school staff

Original: Scanned and uploaded to SSNET

Original: Scanned and sent to Student Transportation Services

Copy: Parent/Guardian

Copy: File in the OSR

**RETAIN: Current school year + 1 year**

Relevant Forms:

P662.02 Staff Administration of Medication

P662.03 Self-Administration of Medication

Medical Incident Record Form