TYPE 1 DIABETES HEALTH CARE PLAN

STUDENT INFORMATION

Date Created:_____

Student Name:_____ Date of Birth:_____

Age:_____ School:_____

Grade:_____ Teacher:_____

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:

❒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 bloom 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 to follow for Severe Hypoglycemia (student is unable to take anything by mouth due to incoherence, irritability, aggressive)

- If available, administer nasal Glucagon by trained adult
- Monitor student, if appropriate place the student on their side in the recovery position
- Call 9-1-1. Do not give food or drink (choking hazard). Supervise student until EMS arrives.
- Contact parent(s)/ guardian(s) or emergency contact

Steps for Severe Hypoglycemia (student is unresponsive, and nasal Glucagon is unavailable)

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.

Form P662.4, November 2018

HYPERGLYCEMIA-HUIGH 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

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. student, designated staff, third party health care provider).

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
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) *Student 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 his/her 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:_____

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) ❒Third party health care provider	Location of insulin:_____ Required times for insulin:_____ ❒Before School ❒Morning Break ❒Lunch Break ❒Afternoon Break ❒Other (Specify):_____ Parent(s)/Guardian(s) Responsibilities: School Responsibilities:_____
ROUTINE	**ACTION (CONTINUED)**
*All students with Type 1 diabetes use insulin. Some students will require insulin during the school day, typically before meal/nutrition breaks.	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 students 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)
DIABETES MANAGEMENT KIT 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.	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). ❒ Nasal Glucagon (please note a Staff Admin of Medication form is required) ❒ Other (please list): _____ _____

	Location of Kit: _____
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

☐ School Staff

Other Individuals to be Contacted Regarding Plan of Care:

Before-School Program ◯ Yes ◯ No _____

After-School Program ◯ Yes ◯ No _____

School Bus Driver ☐ Route #: _____

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)/guardian(s) 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)/guardian(s) to ensure that clear instructions and current physician's orders are provided to the principal.

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

Self-Administration of Medication

Staff Administration of Medication

Medical Incident Record Form (accessed via SSNET)