FEDERAL SCHOOLS

PREVALENT MEDICAL CONDITION — DIABETES

Plan of Care

STUDENT INFORMATION

Student Name: ______________________________

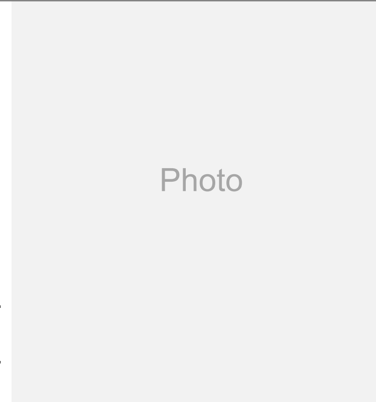
D.O.B.: ______________________________

Age: ______________________________

Grade: ______________________________

School: ____________________ ____________

Teacher(s): ______________________________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EMERGENCY CONTACTS (LIST IN ORDER OF PRIORITY)

Name	Relationship	Daytime Phone	Alternate Phone
1.			
2.			
3.			

DIABETES SUPPORTS

Name(s) of trained individuals who will provide support with diabetes-related tasks: (e.g. designated staff or community care partner(s).

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

Method of home-school communication:
____
____

Please outline any other medical condition or allergy? (Eg: Asthma, Anaphylaxis, Epilepsy)
____
____
____
____

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, outline student self-management process on page 5	

ROUTINE	ACTION
Blood Glucose Monitoring	Target Blood Glucose Range ____________________
Check most relevant box	**Outline responsibilities for box checked under Blood Glucose Monitoring Routine**
❒ Student requires trained individual to check BG/ read meter.	Time(s) to check Blood Glucose: ______________________________ ______________________________
❒ Student needs supervision to check BG/ read meter.	Contact Parent(s)/Guardian(s) if Blood Glucose is: ______________________________
❒ Student can independently check BG/ read meter.	Parent(s)/Guardian(s) Responsibilities: ______________
	______________________________
❒ Student has continuous glucose monitor (CGM)	School Responsibilities: ______________________
✳ Students should be able to check blood glucose anytime, anyplace, respecting their	Student Responsibilities: ______________________ ______________________________

preference for privacy.	
Nutrition Breaks	**Nutrition Breaks Action / Information** **Outline responsibilities for box checked under Nutrition Break Routine**
Check most relevant box	Recommended time(s) for meals/snacks:____________________ ____
❒ Student requires supervision during meal times to ensure completion.	Parent(s)/Guardian(s) Responsibilities:____________________
	____
	School Responsibilities:______________________________
❒ 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.	Student Responsibilities:_____________________________
	Special instructions for meal days/ special events:__________

Sample Meal Plan(s)

ROUTINE	ACTION	
Check most relevant box	**Outline responsibilities for box checked under Insulin Routine**	
INSULIN	Location of insulin: ______________________________	
❒ Student does not take insulin at school.	____	
	Required times for insulin:____________________________	
❒ Student takes insulin at school by:		
❒ Injection	❒ Before school:	❒ Morning Break:
❒ Pump	❒ Lunch Break:	❒ Afternoon Break:
	❒ Other (Specify):_______________________________	
❒ Insulin is given by:		
❒ Student	Parent(s)/Guardian(s) responsibilities:__________________	
❒ Student with		

supervision	School Responsibilities: ______________________________
❒ Parent(s)/Guardian(s)	
❒ Trained Individual	Student Responsibilities: ______________________________
✳ All students with Type 1 diabetes use insulin. Some students will require insulin during the school day, typically before meal/nutrition breaks.	
	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, etc.)

Student Self-management Process: Notes / Comments / Observations

ROUTINE	ACTION
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.) ❒ Carbohydrate containing snacks ❒ Other (Please list) ________________________________
	____
	Location of Kit: ____
Special Needs A student with special needs considerations may require more assistance than outlined in this plan.	**Comments:**
	Actions

Relevant Management Plan for Students with Special Needs
Considerations / Notes / Comments / Observations

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
❒ Skin tone: Pale/ashen/greyish	❒ 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). 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		

Notes / Comments / Observations

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 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: ______________________________________ (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.)		
Parent(s)/Guardian(s): ___________________________________		Date: ________________________
	Signature	
Student: ____		Date:________________________
	Signature	
Principal: ____		Date: ________________________
	Signature	

Notes / Comments / Observations