Dufferin-Peel Catholic District School Board

PLAN OF CARE – PREVALENT MEDICAL CONDITION
TYPE 1 DIABETES

ONCE COMPLETED, THIS FORM ONLY REQUIRES UPDATING IF THE STUDENT'S MEDICAL CONDITION CHANGES.

Student Information

Student Name: _____

Date of Birth: _____

DPCDSB Student Number: _____

Emergency Contact Information:

Name:	Relationship:	Contact Numbers:

Daily Routine Anaphylaxis Management

TO BE COMPLETED BY MEDICAL PRACTITIONER OR HEALTH CARE PROVIDER

- Parent(s)/guardian(s) must provide, maintain, and refresh supplies and the school must ensure this kit is accessible at all times.
- If able, the student will check blood glucose levels as required, allowing for privacy if this is their preference.
- Reasonable accommodations will be provided for student to eat all meals and snacks on time. Student should not trade or share food/snacks with other students.
- Most students will require insulin during the school day, typically before meals/nutrition breaks.
- Physical activity lowers blood glucose (BG). BG is often checked before/after activity. Carbohydrates may need to be eaten before/after physical activity. A source of fast acting sugar must always be within student's reach.

Target Blood Glucose Range: _____ Time(s) to check Blood Glucose: _____

Location of insulin: _____ Required times for insulin: _____

Rescue medication (Baqsimi) has been prescribed: ☐ Yes ☐ No

Student is able to manage their diabetes care independently and does not require any additional support.

☐ Yes — If YES, go directly to **Emergency Procedures** (page 4)

☐ No — If NO, the medical practitioner or health care provider to complete the sections below.

Blood Glucose Monitoring

- ☐ Student requires trained individual to check BG or read meter.
- ☐ Student needs supervision to check BG or read meter.
- ☐ Student can independently check BG or read meter.
- ☐ Student has continuous glucose monitor (CGM)

Insulin

- ☐ Student does not take insulin at school.
- ☐ Student takes insulin at school by:
  - ☐ Injection
  - ☐ Pump
- ☐ Insulin is administered by:
  - ☐ Student
  - ☐ Student with supervision
  - ☐ Parent or guardian
  - ☐ Nurse

Lunch/Nutrition Breaks

- ☐ Student requires supervision during meal times to ensure completion.
- ☐ Recommended lunch and/or nutrition times:

  _____

  _____

- ☐ Student can independently manage their food intake.

Physical Activity

- ☐ Student will do the following when involved in physical activity to help prevent low blood sugar:

  Before: _____

  After: _____

Diabetes Management Kit Contents

- ☐ BG meter
- ☐ BG test strips
- ☐ Lancets
- ☐ Insulin and insulin pen and supplies
- ☐ Source of fast acting sugar (e.g., juice, candy)
- ☐ Carbohydrate/starchy snack (e.g., granola bar, crackers)
- ☐ Other: _____

Other Considerations

_____

Name of insulin: _____ Dosage: _____

Time(s) to administer: _____ Side effects: _____

Special accommodations (if any): _____

Additional instructions (e.g., storage of medication): _____

Disposal of medication _____

Medical Practitioner/ Healthcare Provider Name: _____ Profession/ Role: _____

Signature: _____ Date: _____

Emergency Procedures

HYPOGLYCEMIA – LOW BLOOD GLUCOSE (4 MMOL/L OR LESS)
DO NOT LEAVE STUDENT UNATTENDED

Usual symptoms of hypoglycemia for my child are:

- ☐ Shakiness
- ☐ Blurred vision
- ☐ Paleness/pallor
- ☐ Dizziness
- ☐ Irritability, grouchiness
- ☐ Headache
- ☐ Confusion
- ☐ Hunger
- ☐ Trembling
- ☐ Weakness, fatigue
- ☐ Other: _____

Actions to take for MILD HYPOGLYCEMIA

Step 1: Check blood glucose and give _____ grams of fast acting sugar (e.g., juice, candy).
Step 2: Re-check blood glucose in 15 minutes.
Step 3: If still below 4 mmol/L, repeat steps 1 and 2 until blood glucose is above 4 mmol/L. Give a carbohydrate or starchy snack (e.g., granola bar, crackers) if next meal or snack is more than 1 hour away.

Symptoms of **SEVERE HYPOGLYCEMIA:**

- ☐ Mood swings
- ☐ Dizziness
- ☐ Shaking or sweating
- ☐ Difficulty thinking and speaking
- ☐ Lack of coordination
- ☐ Seizure
- ☐ Loss of consciousness

See page 4 for actions to take…

Actions to take for SEVERE HYPOGLYCEMIA

Step 1: Administer Baqsimi.
Step 2: Call 911. If the student is unconscious, turn them on their side. Supervise student until EMS arrives.
Step 3: Contact parent(s) or guardian(s) or emergency contact.

HYPERGLYCEMIA – HIGH BLOOD GLUCOSE (14 MMOL/L OR MORE)

Usual symptoms of hyperglycemia for my child are:

☐ Extreme thirst	☐ Frequent urination	☐ Headache
☐ Hunger	☐ Abdominal pain	☐ Blurred vision
☐ Warm, flushed skin	☐ Irritability, grouchiness	☐ Other:

_____

Actions to take for MILD HYPERGLYCEMIA

Step 1: Allow student free use of bathroom.
Step 2: Encourage student to drink water ONLY.
Step 3: Inform parent(s) or guardian(s) if blood glucose is above _____ mmol/L.

Actions to take for SEVERE HYPERGLYCEMIA

Symptoms of **SEVERE HYPERGLYCEMIA:**

☐ Rapid, shallow breathing
☐ Vomiting
☐ Fruity breath

Step 1: If possible, confirm hyperglycemia by testing blood glucose.
Step 2: Contact parent(s) or guardian(s) or emergency contact and/or 911 if required.

ADMINISTRATIVE/PLAN REVIEW

Individuals with whom this Plan of Care is to be shared:

☐ Principal or designate	☐ Teacher in Charge	☐ Administrative Assistant(s)
☐ Classroom Teacher(s)	☐ Planning Time Teacher(s)	☐ Resource Teacher(s)
☐ Student Monitors/Volunteers	☐ Occasional Teachers	☐ Support Services

Other individuals to be contacted regarding Plan of Care:

☐ PLASP and/or daycare ☐ Transportation ☐ Other: _____

Parent and Guardian Acknowledgement and Consent

As the parent of: _____, I have been an active participant in supporting the management of my child's medical condition(s) while they are in school.

Teachers and Principals and other school staff are not health professionals and have no more information about the medical condition of my child than what has been provided to them. They are not experts in recognizing the symptoms of my child's medical condition or in treating it.

- ☐ I have educated my child about their medical condition.
- ☐ I have encouraged my child to self-manage and self-advocate.
- ☐ I give consent to share information on signs and/or symptoms with other students (e.g., classmates).
- ☐ I have informed the school of my child's medical condition(s) and will communicate any changes or updates.
- ☐ I will provide a Diabetes Management Kit(s) for the school to store in a central location.
- ☐ My child will carry a Diabetes Management Kit at all times while at school.

This plan remains in effect without change and will be reviewed annually.

It is the responsibility of the parent(s) or guardian(s) to notify the Principal if there is a need to change the Plan of Care.

Parent/ Guardian Signature: _____ Date: _____

Student Signature: _____ Date: _____

Principal Signature: _____ Date: _____