

PREVALENT MEDICAL CONDITION — HYPERINSULEMIA
 Plan of Care

STUDENT INFORMATION

Student Name: _____ Date Of Birth: _____

OEN: # _____ Age: _____ Grade: _____ Weight: _____

- IET
- Resource

Teacher(s): _____

Student Photo

EMERGENCY CONTACTS (LIST IN PRIORITY)

First contact must be a parent.

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

HYPERINSULEMIA SUPPORTS

Names of trained individuals who will provide support with hyperinsulemia-related tasks: (e.g. designated staff or community care allies.)

Method of home-school communication: _____

Any other medical condition or allergy? _____

DAILY/ROUTINE HYPERINSULEMIA MANAGEMENT

Student is able to manage their hyperinsulemia 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>BLOOD GLUCOSE MONITORING</p> <p><input type="checkbox"/> Student requires a 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>NUTRITION BREAKS</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>_____</p> <p>School Responsibilities: _____</p> <p>_____</p> <p>Student Responsibilities: _____</p> <p>Special instructions for meal days/ special events: _____</p> <p>_____</p>

ROUTINE	ACTION (CONTINUED)
<p>ACTIVITY PLAN</p> <p>Physical activity lowers blood glucose. Blood Glucose is often checked before activity. Carbohydrates may need to be eaten before/after physical activity.</p> <p>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> <ol style="list-style-type: none"> 1. Before activity: _____ 2. During activity: _____ 3. After activity: _____ <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>

<p>HYPERINSULEMIA MANAGEMENT KIT</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 include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Blood Glucose meter, BG test strips, and lancets <input type="checkbox"/> Source of fast-acting sugar (e.g. juice, candy, glucose tabs.) <input type="checkbox"/> Carbohydrate containing snacks <input type="checkbox"/> Other (Please list) _____ <p>Location of Kit: _____</p>
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<p>SPECIAL NEEDS</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 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. If below _____ mmol/L, give _____ grams of fast acting carbohydrate provided by parent (e.g. ½ cup juice, 15 skittles)
2. Re-check blood glucose in 15 minutes.
3. If still below _____ mmol/L, repeat steps 1 and 2 until BG is above _____ mmol/L. Give a starchy snack if next meal/snack, _____ is more than one (1) hour away.
4. Call parent/caregiver contact

Steps for **Severe** Hypoglycemia (student is unresponsive)

1. Place the student on their side in the recovery position. Do not give food or drink (choking hazard). Supervise student.
2. Call BSA Nurse STAT
 - If absent, Call **Code Blue** ext. 5555
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

- | | | |
|---|-----------------------------------|--|
| <input type="checkbox"/> Rapid, Shallow Breathing | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Fruity Breath |
|---|-----------------------------------|--|

Steps to take for **Severe** Hyperglycemia

1. Call BSA School Nurse STAT.
 - If absent, Call **Code Blue** ext. 5555
2. Call parent(s)/guardian(s) or emergency contact

EMERGENCY PROCEDURES

Has an emergency rescue medication been prescribed? Yes No

If yes, the following section must be completed by a physician.

Name of Medication

Method of Administration (*Dosage, time of administration*)

Additional Instructions

Name of Physician (*please print*)

Phone #

Signature of Physician

Date

AUTHORIZATION/PLAN REVIEW

I/we authorize the principal or principal designate to share the Plan of Care with school staff who are in direct contact with my child. For example the classroom teacher, educational assistants, therapy team, rotary teachers, occasional staff, appropriate Holland Bloorview staff such as Spiral Garden and pool, transportation providers and volunteers.

Other individuals to be contacted regarding Plan of Care: _____

This plan remains in effect for the completion of the school year and will be reviewed annually. It is the parent's responsibility to notify the principal if there is a need to change the Plan of Care during the school year.

I/we understand our child's personal health information will be disclosed between organizations to maximize the quality of education being provided to our child and this information will be held in confidence and maintained securely in accordance with Ontario's privacy law called the Personal Health Information Protection Act (PHIPA).

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

Principal: _____ Date: _____