Bloorview SCHOOL AUTHORITY

Dream • Learn • Grow

Revised August 2018
Form # **MM.01-03**

PREVALENT MEDICAL CONDITION — TYPE 1 DIABETES
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.			

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
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) ✸ Students 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:_____ _____

ROUTINE	ACTION (CONTINUED)
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) ❒ Trained Individual ✸ All students with Type 1 diabetes use insulin. Some students will require insulin during the school day, typically before meal/nutrition breaks.	Location of insulin: _____ _____ Required times for insulin:_____ ❒ Before school: ❒ Morning Break: ❒ Lunch Break: ❒ Afternoon Break: Dose _____ | Blood Glucose Scale | ❒ 4-6 ❒ 8-12 ***Administration of Prescribed Medication form must be completed and signed by physician.** Additional comments:
ACTIVITY PLAN Physical activity lowers blood glucose. Blood Glucose 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)

ROUTINE	ACTION (CONTINUED)
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 ❒ 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 considerations may require more assistance than outlined in this plan.	Comments:

EMERGENCY PROCEDURES

HYPOGLYCEMIA – LOW BLOOD GLUCOSE
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 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 First Emergency 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 until emergency medical personnel arrives.
2. Call Code Blue ext. 5555
3. Call **9-1-1.**
4. 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

❒ Rapid, Shallow Breathing ❒ Vomiting ❒ Fruity Breath

Steps to take for **Severe** Hyperglycemia

1. Call HCN STAT ext. 5555 to assess.
2. Call Code Blue ext. 5555
3. Call parent(s)/guardian(s) or emergency contact

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: _____