Innovation Collaboration Wellness

Form 311-C

PREVALENT MEDICAL CONDITION — TYPE 1 DIABETES
Plan of Care

STUDENT INFORMATION

Student Name _____ Date Of Birth _____

Ontario Ed. # _____ Age _____

Grade _____ Teacher(s)_____

Student Photo (optional)

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. 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: ❒ Other (Specify):_____ Parent(s)/Guardian(s) responsibilities:_____ School Responsibilities: _____ 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)

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 ❒ 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 considerations may require more assistance than outlined in this plan.	Comments:

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 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.

✸School personnel are not responsible for treating severe low blood glucose with glucagon. Where necessary, arrangements will be made at the school to safely store an accessible supply of glucagon.

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

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: _____

If medication is prescribed and will be administered at school, it is necessary to complete the following documents:

1) Form 314-A1, "Administration of Medication/Medical Procedures to Students"

2) Form 314-A2, :"Authorization and Request Form for the Administration of Prescribed Medication"

Are Forms 314-A1 and Forms 314-A2 required for this student? ❒ Yes ❒ No

TRANSPORTATION

Plan for Student Transportation

Individual Student Boarding	Individual Student Securement	Individual Student De-Boarding

Roles

School Staff	Parent/Guardian	Student	Transportation Provider	Operator/Driver
-Create and monitor this plan with parents/guardians, student, TriBoard, and school staff. -Advise TriBoard and parents/guardians of relevant issues while	-Communicate with the school any medical or other conditions affecting the safe transportation of the student for	-Follow the bus rules and strategies listed on this plan. -Advise the driver of any medical emergency, or health issues that they are	-Ensure that all drivers and monitors staffed to transport the student are aware of the strategies listed in this plan. -Ensure that all temporary staff that	-Ensure that the student is transported safety according to needs listed on this plan. -Follow TriBoard and School Board policies and procedures for

at school during the day. -Help identify tools, or strategies that may help the driver and/or monitor while transporting the student.	completion of this plan. -Communicate any changes to any medical or other conditions that might affect transportation. -Communicate with the school and driver any tool or strategies that will help the driver deliver and monitor the needs of the student while transporting them.	experiencing while being transported. -Communicate with the driver if a listed strategy on this plan needs to be addressed or revisited for their comfort (if possible).	transport the student are aware of the strategies listed in this plan. -Ensure that all temporary staff that transport the student are fully briefed on this plan. -Ensure that proper training of staff is in place regarding boarding, securing, and de-boarding practices to transport student.	transporting students with disabilities. -Communicate with school staff and parents/guardians any concerns, or adjustments that need to be made to this plan.

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: _____

All bus drivers are certified in the administration of First Aid, CPR, and Epi-Pen. These are the only medical procedures a driver may perform. In the event of a student showing signs of medical distress during travel on the school bus, the driver will stop the vehicle in the first safe location, assess the situation, determine if an epi-pen needs to be administered, immediately contact the Bus Operator to request emergency services. The driver will remain with the student until the arrival of the emergency services team. Should a bus driver have occasion to administer First Aid, CPR, or an Epipen, he/she does so in applying the “in loco parentis” principle, not as a health care professional. Visit triboard.ca for complete procedure details. (Triboard)

I consent to the disclosure and use of the personal information collected herein to persons, including persons who are not the employees of the Limestone District School Board through the posting of photographs and medical information of my child (Plan of Care/Emergency Procedures) in the following key locations:

❒ classroom ❒ other: _____

❒ office

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

❒ ***Please Note: Checked box indicates that this student has an additional Plan of Care***