CATHOLIC DISTRICT SCHOOL BOARD OF EASTERN ONTARIO

2755 Highway 43, Kemptville, Ontario K0G 1J0
phone: 613-258-7757 toll free: 1-800-443-4562
www.cdsbeo.on.ca

TYPE 1 DIABETES
Plan of Care (Sample)

Student Information

Student Name: _____ DOB: _____

OEN: _____ Age: _____

Grade: _____ Teacher(s): _____

Any other medical condition or allergy? _____

MedicAlert® ID ☐ Yes ☐ No

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 designates).

_____

_____

Method of home-school communication: _____

Does the student require use of a device to monitor their blood glucose levels? ☐ Yes ☐ No

Note: Diabetes Canada recommends that "schools should permit a student living with diabetes to carry their cell phone as a tool to help manage their blood glucose levels and prevent emergency events. For many students with type 1 diabetes, a cell phone works with insulin pumps and continuous glucose monitoring systems to provide essential information to inform diabetes treatment decisions." This recommendation is in alignment with Policy/Program Memorandum 128, The Provincial Code of Conduct and School Board Codes of Conduct which allows for the use of mobile devices for health and medical purposes.

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 Emergency Procedures section

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ROUTINE	ACTION
Blood Glucose (BG) Monitoring ☐ Student has continuous glucose monitor (CGM)* ☐ Student requires trained individual to check BG/read meter. ☐ Student needs supervision to check BG/read meter ☐ Student can independently check BG/read meter ** *If symptoms fail to match CGM reading, BG must be checked with meter/fingerstick **Students should be able to check blood glucose anytime, any place, respecting their preference for privacy	Target Blood Glucose (BG) 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 their 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: _____ _____

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	Special instructions for meal days/special events: _____ _____
Insulin ☐ Student does not take insulin at school ☐ Student takes insulin at school by: ☐ Injection ☐ Pump ☐ Insulin Pen ☐ Insulin given by: ☐ Student independently ☐ 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 (if not using insulin pump): _____ _____ 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: _____ _____
Physical 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: _____

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	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)
Diabetes Management Kit Parent(s)/Guardian(s) must provide, maintain, and refresh supplies. School must ensure this kit is accessible at all times. (e.g., field trips, fire drills, lockdowns) and advise parent(s)/guardian(s) when supplies are low.	Diabetes Management Kits will be available in different locations and may include: ☐ Blood Glucose meter, BG test strips and lancets ☐ Insulin/Syringes, insulin pens and supplies ☐ Source of fast-acting sugar (e.g., juice, candy, glucose tabs) ☐ Carbohydrate-containing snacks (e.g., granola bar, crackers) ☐ Batteries for BG meter ☐ Other (specify): _____ 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 (4mmol/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 ☐ Pale ☐ Weak/Fatigue ☐ Confused ☐ Other: _____ **Steps to take for mild Hypoglycemia (student is responsive):**

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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.
4. When blood glucose (BG) is above 4 mmol/L, give a starchy snack (e.g. bread, granola bar, cookies, crackers) if next meal/snack is more than one (1) hour away.

Steps to take for sever Hypoglycemia (student is unresponsive)

1. Place the student on their side in the recovery position.
2. Call 911. 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 GLUCOSE (14mmol/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(s)/guardian(s) 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: _____

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. ***

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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 _____ - _____ 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

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

Student: _____ Date: _____
Signature

Principal: _____ Date: _____
Signature