

TYPE 1 DIABETES Plan of Care (Sample)

Student Information

Student Name: _____ DOB: _____

OEN: _____ Age: _____

Grade: _____ Teacher(s): _____

Any other medical condition or allergy? _____

MediAlert® 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 cellphone 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

ROUTINE	ACTION
<p><u>Blood Glucose (BG) Monitoring</u></p> <p><input type="checkbox"/> Student has continuous glucose monitor (CGM)*</p> <p><input type="checkbox"/> Student requires 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>*If symptoms fail to match CGM reading, BG must be checked with meter/fingerstick</p> <p>**Students should be able to check blood glucose anytime, any place, respecting their preference for privacy</p>	<p>Target Blood Glucose (BG) Range:</p> <hr/> <p>Time(s) to check BG:</p> <hr/> <p>Contact parent(s)/guardian(s) if BG is:</p> <hr/> <p>Parent(s)/Guardian(s) responsibilities:</p> <hr/> <hr/> <p>School responsibilities:</p> <hr/> <hr/> <p>Student responsibilities:</p> <hr/> <hr/>
<p><u>Nutrition Breaks</u></p> <p><input type="checkbox"/> Student requires supervision during meal times to ensure completion</p> <p><input type="checkbox"/> Student can independently manage their 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> <hr/> <p>Parent(s)/Guardian(s) responsibilities:</p> <hr/> <hr/> <p>School responsibilities:</p> <hr/> <hr/> <p>Student responsibilities:</p> <hr/> <hr/>

	<p>Special instructions for meal days/special events:</p> <hr/> <hr/> <hr/>
<p><u>Insulin</u></p> <p><input type="checkbox"/> Student does not take insulin at school</p> <p><input type="checkbox"/> Student takes insulin at school by:</p> <p style="padding-left: 20px;"><input type="checkbox"/> Injection</p> <p style="padding-left: 20px;"><input type="checkbox"/> Pump</p> <p style="padding-left: 20px;"><input type="checkbox"/> Insulin Pen</p> <p><input type="checkbox"/> Insulin given by:</p> <p style="padding-left: 20px;"><input type="checkbox"/> Student independently</p> <p style="padding-left: 20px;"><input type="checkbox"/> Student with supervision</p> <p style="padding-left: 20px;"><input type="checkbox"/> Parent(s)/Guardian(s)</p> <p style="padding-left: 20px;"><input type="checkbox"/> Trained individual</p> <p>* All students with Type 1 Diabetes use insulin. Some students will require insulin during the school day, typically before meal/nutrition breaks.</p>	<p>Location of insulin (if not using insulin pump):</p> <hr/> <hr/> <p>Required times for insulin:</p> <hr/> <p><input type="checkbox"/> Before School <input type="checkbox"/> Morning Break</p> <p><input type="checkbox"/> Lunch Break <input type="checkbox"/> Afternoon Break</p> <p><input type="checkbox"/> Other (Specify): _____</p> <p>Parent(s)/Guardian(s) responsibilities:</p> <hr/> <p>School responsibilities:</p> <hr/> <hr/> <p>Student responsibilities:</p> <hr/> <hr/> <p>Additional comments:</p> <hr/> <hr/>
<p><u>Physical Activity Plan</u></p> <p>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.</p>	<p>Please indicate what this student must do prior to physical activity to help prevent low blood sugar:</p> <p>1. Before activity: _____</p> <p>2. During activity: _____</p> <p>3. After activity: _____</p>

	<p>Parent(s)/Guardian(s) responsibilities:</p> <p>_____</p> <p>School responsibilities:</p> <p>_____</p> <p>Student responsibilities:</p> <p>_____</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><u>Diabetes Management Kit</u></p> <p>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.</p>	<p>Diabetes Management Kits will be available in different locations and may include:</p> <p><input type="checkbox"/> Blood Glucose meter, BG test strips and lancets</p> <p><input type="checkbox"/> Insulin/Syringes, insulin pens and supplies</p> <p><input type="checkbox"/> Source of fast-acting sugar (e.g., juice, candy, glucose tabs)</p> <p><input type="checkbox"/> Carbohydrate-containing snacks (e.g., granola bar, crackers)</p> <p><input type="checkbox"/> Batteries for BG meter</p> <p><input type="checkbox"/> Other (specify): _____</p> <p>Location of Kit: _____</p>
<p><u>Special Needs</u></p> <p>A student with special considerations may require more assistance than outlined in this plan.</p>	<p>Comments:</p>

<p>Emergency Procedures</p>
<p>HYPOGLYCEMIA – LOW BLOOD GLUCOSE (4mmol/L or less) DO NOT LEAVE STUDENT UNATTENDED</p>
<p>Usual symptoms of Hypoglycemia for my child are:</p> <p><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</p> <p><input type="checkbox"/> Pale <input type="checkbox"/> Weak/Fatigue <input type="checkbox"/> Confused <input type="checkbox"/> Other: _____</p> <p>Steps to take for mild Hypoglycemia (student is responsive):</p>

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. ***

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