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PREVALENT MEDICAL CONDITION — TYPE 1 DIABETES
Plan of Care

STUDENT INFORMATION

Student Name	**Date Of Birth**	Student Photo (optional)
Ontario Ed. #	Age	
Grade	Teacher(s)	

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?

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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 mealtimes 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: ________________ ________________

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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)

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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:

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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 EMS arrives.
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:

❒ 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

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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 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): ____________ Signature		Date: ____________	
Student: ____________ Signature		Date: ____________	
Principal: Signature		Date:	