NIAGARA CATHOLIC DISTRICT SCHOOL BOARD

STUDENT DIABETES MANAGEMENT PLAN OF CARE **APPENDIX B** Page 1

1. STUDENT PROFILE and INFORMATION

School Year Completed YYYY to YYYY

Student Name | **Birth Date** | **Age**

Current School | **Current Grade** | **OEN**

Teacher(s)

Parent/Guardian

Home Address | **Preferred Phone**

Diabetes Type | **Additional Medical Diagnosis/Diagnoses**

2. EMERGENCY CONTACTS

	Name	Relationship to Student	Preferred Phone	Alternate Phone
1				
2				
3				

IN CASE OF ILLNESS: Blood glucose/sugar levels can drastically fluctuate when a student with diabetes becomes ill (nausea, vomiting, and other flu-like symptoms). In the event of illness/symptoms at school, Parent/Guardian will be contacted. In the event Parent/Guardian is not reached by the preferred phone number listed above, the identified Emergency Contacts will be notified in order of priority listed above.

3. SUPPLIES / EMERGENCY KITS

Parent: Provide supplies to school and maintain/refresh when low.
School: Ensure kit is accessible at all times during school day; advise parent when supplies run low.

Contents (Check all locations that apply)	Student	Classroom	Office	Other Location
Fast-acting sugars:				
Blood glucose meter, test strips, lancing device/lancets				
Carbohydrate snack(s)				
Insulin pen, pen needles, insulin syringe, insulin cartridge				
Ketone strips/meter				
Extra batteries (for meter, pump, etc.)				
Sharps disposal container				
Glucagon (Expiry date: MM/YY)				
Parent/Emergency names and contact information				
Continuous glucose monitoring system				
Other: If required				

**This information is being collected pursuant to the provisions of the Municipal Freedom of Information and Protection of Privacy Act and under the Authority of the Education Act, and will be used by Student Support. Questions about this collection should be directed to the Superintendent of Education – Student Support, Niagara Catholic District School Board, 427 Rice Road, Welland, Ontario L3C 7C1, 905-735-0240.*

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STUDENT DIABETES MANAGEMENT PLAN **APPENDIX B** Page 2

Student Name _____ **School Year Completed** _____ to _____

4. BLOOD GLUCOSE/SUGAR (BG) MONITORING

Student's Independence Level: Student can manage food intake independently.
Student requires supervision at breaks and meals to ensure all food is eaten.

Support/Supervision provided by: _____

Student's target blood sugar (BG) range: 0.00 to 0.00 mmol/L **Call parent if blood sugar is:** Below 0.00 Above 00.00

Glucose meter(s) location: ☐ Student ☐ Classroom ☐ Office ☐ Other

Daily blood sugar monitoring schedule

	Time: 00:00 AM/PM		Time: 00:00 AM/PM
☐ AM Break		☐ Before leaving school	
☐ Lunch		☐ Before physical activity	
☐ PM Break		☐ Other time(s):	

Home-School BG communication method: _____

Does the student use a continuous glucose monitoring (CGM) device? Yes / No / Sometimes (If Yes or Sometimes, **complete Section 8.**)

5. MEALS and NUTRITION BREAKS

Ensure student has their nutrition break and meals on time.

Student's Independence Level : Student can manage food intake independently.
Student requires supervision at breaks and meals to ensure all food is eaten.

Nutrition break and meal times: Student can eat at regular school times.
Student should eat at the specified times: _____

☐ **Student requires food at end of day/dismissal.**

☐ **When treats or other food is provided in the classroom:** Student can manage independently.
Contact parent in advance for instructions.

☐ **Student has food restrictions (allergies, intolerances, etc.):** _____

☐ **Carbohydrate counting/calculations and labeling carb count on food is the responsibility of Parents/Guardians.**

6. PHYSICAL ACTIVITY and EXCURSIONS AWAY FROM SCHOOL*

Student's Independence Level : Student can make decisions about physical activity independently
Student requires supervision/guidance around physical activity

Before physical activity: No action required before physical activity.
Check blood sugar before any physical activity and follow Physical Activity Plan I

Physical Activity Plan: *(If required)*

1. **LOW:** If BG is under _____ mmol/L, treat for low blood sugar.
2. If BG is between _____ mmol/L and _____ mmol/L, give a snack before physical activity
3. **HIGH:** If BG is between _____ mmol/L and _____ mmol/L, no snack is needed before physical activity

For students with an insulin pump: No pump adjustments needed.
Suspend/disconnect pump for activity.

***School and Home must determine an alternate plan for blood glucose/sugar monitoring and support (if student is not independently capable) for excursions away from school location or outside of the regular school day when LHIN-provided Nursing is not available.**

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STUDENT DIABETES MANAGEMENT PLAN **APPENDIX B** Page 3

Student Name _____ **School Year Completed** _____ to _____

7. INSULIN ADMINISTRATION

☐ **Student does not take insulin at school** (Do not complete this section)

Insulin administration method: Insulin pump / Pen injection / Syringe / Inhaler

Insulin administered by: Student, independently / Parent / Nurse / Other (Specify) _____

Insulin administration schedule

Time: 00:00 AM/PM

☐ AM Break _____ ☐ PM Break _____

☐ Lunch _____ ☐ Other _____

PUMP ROUTINE and MANAGEMENT PLAN	PEN/SYRINGE ROUTINE and MANAGEMENT PLAN
☐ Parent provides a bolus calculator ☐ Pump is always programmed at home **Insulin administrator identified above will:** 1. Check BG before student eats. The reading is: ☐ Sent to pump by the meter. ☐ Entered manually into the pump. 2. Enter the total number of carbohydrates to be eaten (provided by home) 3. Pump will calculate amount of insulin to be given. Press the button to accept and deliver the bolus. **If BG is above** _____ **mmol/L:** ☐ Check ketones ☐ Call Parent(s) ☐ Other: Specify. _____	**Type of insulin used:** _____ **Insulin calculator/administrator:** Student, independently / Parent / Nurse / Other (Specify) ☐ Parent labels food with number of carbohydrates and provides bolus calculator to select appropriate insulin dose based on BG reading and number of carbohydrates. ☐ Same as above, with dose calculated by glucose meter. ☐ Parent send **set number of carbohydrates** for each meal each day. Parent provides an appropriate tool to help select appropriate insulin dose based on student's BG. ☐ Parent send **different number of carbohydrates** for each meal each day. Parent provides an appropriate tool to help select appropriate insulin dose based on student's BG.

8. CONTINUOUS GLUCOSE MONITOR (CGM) ROUTINE AND MANAGEMENT

Student's target blood sugar (BG) range _____ to _____ mmol/L **Call parent if blood sugar is:** Below _____ Above _____

Student's Independence Level:
*Excluding incidences of severe hypoglycemia
Student is independent in their response to CGM results and alarms.
Student requires assistance to respond to CGM results and alarms.

CGM Results are sent to: ☐ Insulin pump** ☐ Remote device ☐ Parent smart device

** ☐ Low Glucose Suspend is active on pump

** ☐ If LGC is active, threshold is set at _____ mmol/L.

Low BG Alarm is set at: _____ mmol/L.
Low BG alarm should be confirmed with a BG check. Respond as per Student Diabetes Emergency Action Plan (Appendix C).

High BG Alarm is set at: _____ mmol/L.
High BG alarm should be confirmed with a BG check. Respond as per Student Diabetes Emergency Action Plan (Appendix C).

IN THE EVENT OF A CGM DEVICE MALFUNCTION, IMMEDIATELY CONTACT PARENT/GUARDIAN FOR INSTRUCTIONS.

Student Name _____ **School Year Completed** _____ to _____

9. PARENT PRE-AUTHORIZATION and CONSENT

Consent to release and share information*: I authorize and provide consent to school staff to use and/or share information in this plan for purposes related to the education, health, and safety of my child. This may include:

1. Displaying my child's photograph and/or additional information on paper notices or electronic formats(s) so that staff, volunteers, and school visitors will be aware of my child's medical condition
2. Communicating with bus operators
3. Sharing information in special circumstances to protect the health and safety of my child.

Consent to transfer to hospital: I consent in advance to my child's being transported to a hospital if required, based on the judgement of school staff. I also permit a staff member to accompany my child during transport. I agree that the school's administrator or designate shall decide if an ambulance is to be called.

Consent to treatment: I am aware that school staff are not medical professionals and perform all aspects of this plan to the best of their abilities and in good faith. I approve of the management steps and responses outlined in this care plan.

Consent for annual review (Appendix D): I am aware that school staff will request my involvement in an annual review of this management plan, and when requirements change significantly, they will request my involvement in completing a new plan.

10. AUTHORIZATION and SIGNATURES

Parent/Guardian (Print): _____

Parent/Guardian Signature(s): _____

Date Signed: _____

School Administrator (Print): _____

School Administrator Signature: _____

Date Signed: _____

Health Care Provider (Print): _____

Health Care Provider Signature: (optional) _____

Date Signed: _____

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