|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1. STUDENT PROFILE and INFORMATION** | | | **School Year Completed** | | | | to | | | |
| **Student Name** |  | | | **Birth Date** | | |  | | **Age** | 00 |
| **Current School** |  | | | **Current Grade** | | | *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: | Specify type of fast-acting sugars used | |  |  |  |  |
| 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: ) | | |  |  |  |  |
| Parent/Emergency names and contact information | | |  |  |  |  |
| Continuous glucose monitoring system | | |  |  |  |  |
| Other: If required | | |  |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **4. BLOOD GLUCOSE/SUGAR (BG) MONITORING** | | | | | |  | | | | | | | | |
| **Student’s Independence Level:** | | |  | | | | | | | | | | | |
| **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 | |  | |
| **Daily blood sugar monitoring schedule** | | | | | | | | | | | | | |
| AM Break | **Time: AM/PM** | | | | | | | Before leaving school | | | | **Time: AM/PM** | |
| Lunch | **Time: AM/PM** | | | | | | | Before physical activity | | | |  | |
| PM Break | **Time: AM/PM** | | | | | | | Other time(s): | | | | **Time: AM/PM** | |
| **Home-School BG communication method:** | | | | |  | | | | | | | | |
| **Does the student use a continuous glucose monitoring (CGM) device?** Choose(If Yes or Sometimes, **complete Section 8.**) | | | | | | | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | | | |
| **5. MEALS and NUTRITION BREAKS** | | Ensure student has their nutrition break and meals on time.  Allow enough time for them to eat. No food sharing. | | | |
| **Student’s Independence Level** : |  | | | | |
| **Nutrition break and meal times:** |  | | |  | |
| **Student requires food at end of day/dismissal.** | | |  | | |
| **When treats or other food is provided in the classroom:** | | |  | | |
| **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** : | |  | |
| **Before physical activity:** | |  | |
| **Physical Activity Plan:** | 1. **LOW:** If BG is under mmol/L, treat for low blood sugar. | | |
| *(If required)* | 1. If BG is between mmol/L and mmol/L, give a snack before physical activity | | |
|  | 1. **HIGH:** If BG is between mmol/L and mmol/L, no snack is needed before physical activity | | |
| **For students with an insulin pump:** | |  | |
| **\*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.** | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **7. INSULIN ADMINISTRATION** | | | **Student does not take insulin at school** (Do not complete this section) | | | | |
| **Insulin administration method**: | | |  | | | | |
| **Insulin administered by:** | | |  |  | | | |
| **Insulin administration schedule** | | | | | | | |
| AM Break | | **Time: AM/PM** | | | PM Break | **Time: AM/PM** |
| Lunch | | **Time: AM/PM** | | | Other | **Time: AM/PM** |
|  | | | | | | |
| **PUMP ROUTINE and MANAGEMENT PLAN** | | | | | **PEN/SYRINGE ROUTINE and MANAGEMENT PLAN** | |
| Parent provides a bolus calculator | | | | | **Type of insulin used:** | |
| Pump is always programmed at home | | | | | **Insulin calculator/administrator:** | |
| **Insulin administrator identified above will:** | | | | | Parent labels food with number of carbohydrates and provides bolus calculator to select appropriate insulin dose based on BG reading and number of carbohydrates. | |
| 1. Check BG before student eats. The reading is: | | | | |
| Sent to pump by the meter. | | | | | Same as above, with dose calculated by glucose meter. | |
| Entered manually into the pump. | | | | | 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. | |
| 1. Enter the total number of carbohydrates to be eaten (provided by home) | | | | |
| 1. Pump will calculate amount of insulin to be given. Press the button to accept and deliver the bolus. | | | | |
| **If BG is above mmol/L:** | | | | | 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. | |
| Check ketones | | Call Parent(s) | | |
| Other: |  | | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **8. CONTINUOUS GLUCOSE MONITOR (CGM) ROUTINE AND MANAGEMENT** | | | | | | | | | | |
| **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 |
| **Student’s Independence Level**:  \*Excluding incidences of severe hypoglycemia | |  | | | | | | | |
| **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).**](https://docushare.ncdsb.com/dsweb/Get/Document-1923044/Appendix%20C%20Student%20Diabetes%20Emergency%20Action%20Plan.pdf) | | | | | | | | | |
| **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).**](https://docushare.ncdsb.com/dsweb/Get/Document-1923044/Appendix%20C%20Student%20Diabetes%20Emergency%20Action%20Plan.pdf) | | | | | | | | | |
| **IN THE EVENT OF A CGM DEVICE MALFUNCTION, IMMEDIATELY CONTACT PARENT/GUARDIAN FOR INSTRUCTIONS.** | | | | | | | | | |
| **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):**](https://docushare.ncdsb.com/dsweb/Get/Document-1923045/Appendix%20D%20Student%20Diabetes%20Management%20Plan%20of%20Care.pdf) 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:** |  | | | | | | | | | |