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 *Enter Student Name* **Birth Date** YYYY-MM-DD **Age** 00

Current School *Enter School Name* **Current Grade** *Grade* **OEN** 000-000-000

Teacher(s) *Enter Teacher Name*

Parent/Guardian *Please include Parent(s)/Guardian(s) First and Last Names*

Home Address *Enter Street Address, Municipality, Postal Code* **Preferred Phone** 000-000-0000

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

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	☐	☐	☐	☐ Name Location
Blood glucose meter, test strips, lancing device/lancets	☐	☐	☐	☐ Name Location
Carbohydrate snack(s)	☐	☐	☐	☐ Name Location
Insulin pen, pen needles, insulin syringe, insulin cartridge	☐	☐	☐	☐ Name Location
Ketone strips/meter	☐	☐	☐	☐ Name Location
Extra batteries (for meter, pump, etc.)	☐	☐	☐	☐ Name Location
Sharps disposal container	☐	☐	☐	☐ Name Location
Glucagon (Expiry date: MM/YY)	☐	☐	☐	☐ Name Location
Parent/Emergency names and contact information	☐	☐	☐	☐ Name Location
Continuous glucose monitoring system	☐	☐	☐	☐ Name Location
Other: If required	☐	☐	☐	☐ Name Location

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

Student Name *Enter Student Name* **School Year Completed** YYYY to YYYY

4. BLOOD GLUCOSE/SUGAR (BG) MONITORING

Student's Independence Level: Select Independence Level that best represent student ability.

Support/Supervision provided by: Indicate who will support/supervise monitoring if student is not independently capable.

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

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

Home-School BG communication method: Specify

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 : Select Independence Level that best represent student ability.

Nutrition break and meal times: Choose an item. Specified meal times (if requird).

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

☐ **When treats or other food is provided in the classroom:** Choose an item.

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

☐ **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 : Select Independence Level that best represent student ability.

Before physical activity: Choose an item.

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: Choose an action item for insulin pump during physical 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 Name *Enter Student Name* **School Year Completed** YYYY to YYYY

7. INSULIN ADMINISTRATION

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

Insulin administration method: Choose a method.

Insulin administered by: Please choose. Specify Other

Insulin administration schedule

☐ AM Break	Time: 00:00 AM/PM	☐ PM Break	Time: 00:00 AM/PM
☐ Lunch	Time: 00:00 AM/PM	☐ Other	Time: 00:00 AM/PM

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:** List all insulin types used. **Insulin calculator/administrator:** Please choose. ☐ 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 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
Select Independence Level that best represent student ability.

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 *Enter Student Name* **School Year Completed** YYYY to YYYY

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: _____

Commented [DGJ1]: AS per PPM 161

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