PREVALENT MEDICAL CONDITION DIABETES
PLAN OF CARE

STUDENT INFORMATION		Student Photo
Student Name:		
Student wears Medical-Alert Bracelet YES NO		
Date of Birth	Age:	
Teacher	Grade:	☐ **I consent to publicly displaying this photo.**

EMERGENCY CONTACTS in ORDER

Name	Relationship	Phone #
1.		
2.		
3.		
4.		

MEDICATION

Has medication been prescribed to manage this condition? Yes No
Has emergency recovery medication been prescribed? Yes No

If yes, this plan must be shared with your physician and the following section (appendix A) must be completed by a physician.

NCCSA AUTHORIZATION OF PROVISION OF ORAL/TOPICAL Prescription MEDICATION

TYPE ONE DIABETES SUPPORTS

Names of trained individuals who will provide support with diabetes-related tasks.	
Method of home-school communication	

STUDENT NAME:

DAILY MANAGEMENT

Student is able to manage their diabetes care independently and does not require any special care from the school.

Yes No
If YES, please go directly to 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)	Target Blood Glucose Range _____ Time(s) to check BG: _____ Contact Parent(s)/ Guardians if BG is _____ Parent(s)/Guardian(s) Responsibilities: _____ School Responsibilities:_____ Student Responsibilities: _____ *Students should be able to check blood glucose anytime, anyplace, respecting their preference for privacy*
NUTRITION BREAKS ☐ Student requires supervision during meal times to ensure completion ☐ Student can independently manage his/her food intake	Recommended time(s) for meals/snacks: _____ Parent(s)/Guardian(s) Responsibilities: _____ School Responsibilities:_____ Student Responsibilities: _____ Special instructions for meal days/special events: _____ _____ *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 snacks/food with other students*
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)/Guardians ☐ Trained individual	Location of insulin: _____ Required times for insulin: _____ ☐ Before school ☐ Lunch break ☐ Afternoon break Parent(s)/Guardian(s) Responsibilities: _____ School Responsibilities:_____ Student Responsibilities: _____ *All students with Type 1 diabetes use insulin. Some students will require insulin during the school day, typically before meal/nutrition breaks*
ACTIVITY PLAN Physical activity lowers blood glucose. BG is often checked before activity. Carbohydrates may need to be eastern before/after physical activity. A source of fast-acting sugar must always be within students' reach.	Please indicate what this sugar must do prior to physical activity to help prevent low blood sugar: Before activity:_____ During activity: _____ 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*

STUDENT NAME:

DIABETES MANAGEMENT KIT Parents must provide, maintain, and refresh supplies. School must ensure this kit is accessible all times 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 (eg. juice, candy, glucose tabs) ☐ Carbohydrate containing snacks ☐ Other (Please list)_____ ☐ Location of Kit_____

NCCSA EMERGENCY PROCEDURES FOR DIABETES

HYPOGLYCEMIA – LOW BLOOD GLUCOSE

(4 mmol/L or less)

DO NOT LEAVE STUDENT UNATTENDED

TYPICAL SIGNS OF HYPOGLYCEMIA FOR MY CHILD INCLUDE:	☐ 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 the 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** **3. Do not give food or drink (choking hazard).** **4. Supervise the student until emergency medical personnel arrive.** **5. Contact parent(s)/guardian(s) or emergency contact**

HYPERGLYCEMIA — HIGH BLOOD GLUCOSE

(14 MMOL/L OR ABOVE)

Usual Signs of HYPERGLYCEMIA for my child include:	☐ Extreme Thirst ☐ Frequent Urination ☐ Headache ☐ Hungry ☐ Abdominal Pain ☐ Blurred Vision ☐ Warm, Flushed Skin ☐ Irritability ☐ Other:

STUDENT NAME:	
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	☐ Rapid Shallow Breathing ☐ Vomiting ☐ Fruity Breath
Steps to take for SEVERE Hyperglycemia	1. If possible, confirm hyperglycemia by testing blood glucose **NOTIFY PARENTS IMMEDIATELY**

Does the student have any other Prevalent Medical Conditions for which there is a Plan of Care?

Yes No

If Yes, check all that apply:

- ☐ Anaphylaxis
- ☐ Asthma
- ☐ Epilepsy/Seizures
- ☐ Concussion
- ☐ General: _____

INDIVIDUALS with whom THIS PLAN OF CARE WILL BE SHARED

- ☐ **I/we authorize the principal to share the Plan of Care with school staff who are in direct contact with my child.**
- ☐ **I/we are aware that the school will share this Plan of Care with:**
  - ☐ **Niagara Children's Centre**
  - ☐ **Nursing (if applicable)**
  - ☐ **Transportation Provider**

This plan of care remains in effect for the _____ School Year and will be reviewed within the first 30 days of a new school year
If at that time, there are no changes to the student medical history, this information may remain on file.
It is the responsibility of parents to notify the principal if there is a need to change this plan during the school year.

Parent Signature:	Date:
Student Signature:	Date:
Principal Signature:	Date:

Appendix A

niagara children's centre school Weaving education and therapy together for student success.
AUTHORIZATION OF PROVISION OF ORAL/TOPICAL PRESCRIPTION MEDICATION
TO BE COMPLETED BY PARENT/GUARDIAN

STUDENT NAME		
BIRTHDATE		**GRADE**
ADDRESS		**PHONE NUMBER**
PARENT NAME		

HEALTH CARE PROVIDER INFORMATION
Please review the NCCSA Plan of Care with your healthcare provider.

Provider Name	Provider Address and Phone Number	☐ Physician ☐ Nurse Practitioner
Special Instructions from Health Care Provider		

Name of Medication	
DATE	
Date prescribed	
Dosage to be provided each time	
Times dosage to be provided	
Method of administration	
Possible side effects	
Storage and safekeeping s	

PARENT/GUARDIAN APPROVAL
I hereby request and give permission to NCCSA to provide Oral/topical prescription medication to my child according to NCCSA procedures and the instructions provided.
I also affirm that the medication provided is the medication stated on the container provided to the school.

Signature of Health Care Provider **Optional** UNLESS medication is rescue medication.		
Signature of Parent/Guardian		DATE: