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INDIVIDUALIZED PLAN FOR A CHILD WITH TYPE 1 DIABETES

Child's Full Name:			Photo of Child (Recommended)
Child's Date of Birth:			
Gender:	☐ **Male** ☐ **Female**		
Child's Home Address:			
Health Card Number:			
Date Plan Completed:			
Physician Name:		**Physician Phone Number:**	

EMERGENCY CONTACT 1	**EMERGENCY CONTACT 2**
Name: _____	Name: _____
Home: _____	Home: _____
Work: _____	Work: _____
Cell: _____	Cell: _____

TYPE 1 DIABETES PREVENTION AND SUPPORT
STEPS TO REDUCE THE RISK OF CAUSING OR WORSENING THE MEDICAL CONDITION(S): *(include how to prevent a medical emergency)*

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TYPE 1 DIABETES PREVENTION AND SUPPORT (cont'd)
LIST OF MEDICAL DEVICES AND HOW TO USE THEM *(if applicable):* *(ex. Glucose monitor, insulin pump)*
LOCATION OF MEDICATION AND/OR MEDICAL DEVICE(S) *(if applicable):* *(ex. Glucose monitor is stored on the second shelf in the program room storage closet; or not applicable N/A)*
SUPPORTS AVAILABLE TO THE CHILD *(if applicable):*
Any other medical condition or allergy?: ☐ **Yes** – *if yes, please also complete an Individual Medical Emergency Plan* ☐ **No**

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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 –** *If Yes, go directly to page five (5), Emergency Procedures* ☐ **No**

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 meal times 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
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: _____ _____

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ROUTINE	ACTION
DIABETES MANAGEMENT KIT Parent(s), Guardian(s) must provide, maintain, and refresh supplies. School must ensure this kit is accessible at all times (ex. Field trips, fire drills, lockdowns etc.) 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): _____ _____ □ **Glucagon*** ***I give the school permission to administer glucagon <u>and</u> to train staff on use** _____ *Parent/Guardian Signature* Location of Kit: _____
SPECIAL NEEDS A student with special considerations may require more assistance than outlined in this plan.	Comments:

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SYMPTOMS AND EMERGENCY PROCEDURES

HYPOGLYCEMIA – LOW BLOOD GLUCOSE
(3.9 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 3.9 mmol/L, repeat steps 1 and 2 until BG is above 3.9 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. Administer glucagon.
2. Place the student on their side in the recovery position.
3. Call 9-1-1. Do not give food or drink (choking hazard). Supervise student until emergency medical personnel arrives.
4. Contact parent(s)/guardian(s) or emergency contact.

HYPERGLYCEMIA – HIGH BLOOD GLUCOSE
(15 mmol/L or more)

Usual symptoms of Hypoglycemia 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, test for ketones.
2. Call parent(s)/guardian(s) or emergency contact if _____ ketones are present.

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PROCEDURES TO FOLLOW DURING AN EVACUATION: *(ex. how to assist the child to evacuate)*

PROCEDURES TO FOLLOW DURING FIELD TRIPS: *(ex. How to plan for an off-site excursion; how to assist and care for the child during a field trip.)*

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include anyone from student's Type 1 Clinic Team (ex. Doctor, Nurse, Dietician, Social Worker)

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____

Special Instructions/Notes/Prescription Labels:

If any other medication is prescribed, please complete the ***Authorization for Administration of Prescription Form***.

AUTHORIZATION/PLAN REVIEW

This plan of care will be shared with your student's Homeroom Teachers, Specialty Teachers and the Extended Hours Program.

This plan remains in effect for the 2019-2020 school year without change and will be reviewed on or before: _____. (It is the parent(s)/guardian(s) responsibility to notify Homeroom Teachers and the Academic Director if there is a need to change the plan of care during the school year. **This plan must be reviewed on an annual basis.**

Parent(s)/Guardian(s): _____ Date: _____
Signature

Academic Director: _____ Date: _____
Signature