YORK CATHOLIC DISTRICT SCHOOL BOARD

DIABETES HEALTH MANAGEMENT PLAN
PART A: DAILY MANAGEMENT PLAN

STUDENT'S NAME: _____ **TEACHER'S NAME:** _____

DATE OF BIRTH: _____ **GRADE:** _____

PARENT'S NAME: _____ **PHONE #:** _____

PARENT'S NAME _____ **PHONE #:** _____

ALTERNATE EMERGENCY CONTACT INFO: _____

Home Address _____ _____ Phone # _____ Physician's Name _____ Phone #	**PLACE STUDENT'S PHOTO HERE (MUST BE KEPT CURRENT)**

Names of trained adults who will provide support with diabetes-related tasks (e.g. designated staff or community care allies):

Names of trained adults that can administer nasal glucagon:

Method of home-school communication:

Any other medical condition or allergy?

Time of day when low blood sugar is most likely to occur:

What has been provided to treat low blood sugar symptoms:

Emergency glucagon medication provided by parent ☐Yes ☐No

☐ Nasal – to be administered by trained adult
☐ Glucagon via injection – to be administered by paramedics, nurse, or parent

Where the sugar source is located: _____

Children with diabetes must eat their snacks and meals as outlined in the management plan.

Morning Snack Time: _____ Lunch Time: _____ Afternoon Snack Time: _____

Children with diabetes should never be refused water to drink or bathroom privileges.

DAILY/ROUTINE DIABETES HEALTH MANAGEMENT PLAN

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

❒ Yes ❒ No

❒ If Yes, go directly to page five (5) — 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) ✸ 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:_____ _____

ROUTINE	ACTION (CONTINUED)
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 (Nurse) ✸ 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: _____ For special events, notify parent(s)/guardian(s) in advance so that appropriate adjustments or arrangements can be made. (e.g. extracurricular, Terry Fox Run)

ROUTINE	ACTION (CONTINUED)
DIABETES MANAGEMENT KIT Parent(s)/Guardian(s) must provide, maintain, and refresh supplies. School must ensure this kit is accessible all times. (e.g. field trips, fire drills, lockdowns) 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) _____ _____ Location of Kit: _____
SPECIAL NEEDS A student with special considerations may require more assistance than outlined in this plan.	Comments:

EMERGENCY PROCEDURES

HYPOGLYCEMIA – LOW BLOOD GLUCOSE (4 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 4 mmol/L, repeat steps 1 and 2 until BG is above 4 mmol/L. Give a starchy snack if next meal/snack is more than one (1) hour away.

Steps for Severe Hypoglycemia (student is unable to take anything by mouth due to incoherence, irritability, unresponsiveness)

1. Place the student on their side in the recovery position.
2. Call 9-1-1. Do not give food or drink (choking hazard). Supervise student until EMS arrives.
3. As per parent request, trained adult to administer nasal glucagon.
4. Contact parent(s)/guardian(s) or emergency contact.

HYPERGLYCEMIA — HIGH BLOOD GLOCOSE (14 MMOL/L OR ABOVE)

Usual symptoms of hyperglycemia 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, confirm hyperglycemia by testing blood glucose
2. Call parent(s)/guardian(s) or emergency contact

HEALTHCARE PROVIDER INFORMATION (OPTIONAL)

Healthcare provider may include: Physician, Nurse Practitioner, Registered Nurse, Pharmacist, Respiratory Therapist, Certified Respiratory Educator, or Certified Asthma Educator.

Healthcare Provider's Name: _____

Profession/Role: _____

Signature: _____ Date: _____

Special Instructions/Notes/Prescription Labels:

If medication is prescribed, please include dosage, frequency and method of administration, dates for which the authorization to administer applies, and possible side effects.
✸This information may remain on file if there are no changes to the student's medical condition.

AUTHORIZATION/PLAN REVIEW

INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED

1. _____ 2._____ 3._____

4._____ 5._____ 6._____

Other Individuals To Be Contacted Regarding Plan Of Care:

Before-School Program ❒Yes ❒ No _____

After-School Program ❒ Yes ❒ No _____

School Bus Driver/Route # (If Applicable) _____

Other: _____

This plan remains in effect for the 20___— 20___ school year without change and will be reviewed on or before as required: _____ (It is the parent(s)/guardian(s) responsibility to notify the Principal if there is a need to change the plan of care during the school year).

Physician: _____ Date: _____
Signature

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

Student: _____ Date:_____
Signature

Principal: _____ Date: _____
Signature

APPENDIX A
Sent annually with current S16b

Diabetes Health Management Parent/Guardian Letter

School Letterhead

Date

Dear Parent/Guardian:

As we update our school records related to your child's Diabetes Health Management Plan (S16b), I am requesting that you carefully review, update, complete, sign and return the attached S16b and the Consent for Consultation with Board Staff (SE3) to the school office. This information is necessary for the safety and protection of your child.

It is the responsibility of the Parent(s)/Guardian(s) to ensure that all medical information pertinent to your child's diabetes is always current. Please complete and return the attached forms with a physician signature.

If revisions to the medical information outlined on the attached forms are necessary, you will be required to complete a new form and secure an updated physician signature. If no revisions are necessary, please return the signed Form S16b with an updated photo of your child.

Please contact the school office if you have any questions and/or concerns.

Thank you for your immediate attention to this request and your ongoing support in the shared responsibility for management of your child's diabetes at school.

Please return all forms as soon as possible.

Sincerely,

Principal Name

S16b1
Nov. 2018

YORK CATHOLIC DISTRICT SCHOOL BOARD

STUDENT BLOOD SUGAR LOG
(Optional)

Student: _____

Teacher: _____

Grade/Class: _____ Week or Month of: _____

BLOOD SUGAR LOG						
Date	Time	Level	Checked by (print name)	Initial	Signs/symptoms of low blood sugar observed (if any)	Actions taken

c.c. Office Copy (current school year)
File with S16b in OSR for the following school year