APPENDIX A
S16(b)
Rev. May 2023

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 NUMBER:** _____

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

Home Address: Physician's Name: Phone Number: Address:	**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:	
Emergency glucagon medication provided by parent ☐Yes ☐No	
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:	

☐ 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.

EMERGENCY PROCEDURES

HYPOGLYCEMIA – LOW BLOOD GLUCOSE (BG) (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 (BG), 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 unable to take anything by mouth due to incoherence, irritability, unresponsiveness)

1. Place the student on their side Nasal glucagon to be administered by trained adult with parent(s)/guardian(s) consent
3. Call 9-1-1. Do not give food or drink (choking hazard)
4. Contact parent(s)/guardian(s) or emergency contact
5. Supervise students until EMS arrives. Follow the direction of medical staff.

HYPERGLYCEMIA — HIGH BLOOD GLUCOSE (BG) (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(s)/guardian(s) 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

DAILY/ROUTINE DIABETES HEALTH MANAGEMENT PLAN

Students are 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 two (2) — 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 their food intake. □ Reasonable accommodation must be made to allow student to eat all of the provided meals	Recommended time(s) for meals/snacks: Parent(s)/Guardian(s) Responsibilities: School Responsibilities: Student Responsibilities:

and snacks on time. Students should not trade or share food/snacks with other students.	Special instructions for meal days/ special events:

INSULIN ☼ 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 at 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:

HEALTHCARE PROVIDER INFORMATION

Healthcare providers 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 HEALTH MANAGEMENT PLAN IS TO BE SHARED

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Other Individuals To Be Contacted Regarding ~~Plan Of Care~~ the Health Management Plan: 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: _____ Please complete parent(s)/guardian(s) consent form S16d each year. (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