BOARD OF EDUCATION BURNABY SCHOOL DISTRICT 41

FORM B

PEN #

DIABETES SUPPORT PLAN & Medical Alert Information

Refer to Medical Information Form

Student Photo

STUDENT INFORMATION – *completed by parent/guardian* □ **Wears Medic Alert ID**

Student Name: _____ DOB: y/m/d _____ Plan current for ____/____ school year

School: _____ Grade: _____Div: _____ PHN Care Card Number: _____

Nursing Support Services Diabetic Delegated Care Plan □ yes □ no Date of Care Plan: _____

NSS Coordinator: _____ Phone: _____

CONTACT INFORMATION – *completed by parent / guardian*

Parent/Guardian 1:	Name:			□ call first
Phone numbers:	Cell:	Work:	Home:	Other:
Parent/Guardian 2:	Name:			□ call first
Phone numbers:	Cell:	Work:	Home:	Other:
Other/Emergency:	Name: Able to advise on diabetes care: □ yes □ no			Relationship:
Phone numbers:	Cell:	Work:	Home:	Other:

Additional times to contact Parent/Guardian (In addition to times indicated in NSS Delegated Care Plan):

Parent/Guardian Signatures:

Name: _____ Signature: _____ Date: _____

Name: _____ Signature: _____ Date: _____

School staff trained to give Glucagon – *completed by school administrator*

Name: _____ Position: _____ Date of Training: ___/____/____

Name: _____ Position: _____ Date of Training: ___/____/____

Fast acting sugar: □ with student □ in classroom □ in office Other: _____

Glucagon Kit: □ with student □ in classroom □ in office Other: _____

Glucagon dose: _____ 0.5 mg (5 years old or less) _____ 1 mg (6 years or older)

Has parent/guardian provided emergency supplies in the event of a natural disaster? □ yes □ no

DIABETES MEDICAL ALERT INFORMATION

Student: _____

Physician Authorization *– the student's physician must complete the following information and sign this plan.*

MEDICAL ALERT - TREATING MILD TO MODERATE LOW BLOOD GLUCOSE
NOTE: PROMPT ATTENTION CAN PREVENT SEVERE LOW BLOOD SUGAR

SYMPTOMS	TREATMENT FOR STUDENTS NEEDING ASSISTANCE (anyone can give sugar to a student):
□ Shaky, sweaty □ Dizzy □ Irritable □ Tired/sleepy □ Blurry vision □ Confused □ Poor coordination □ Difficulty speaking □ Headache □ Difficulty concentrating □ Pale □ Hungry Other:	Location of fast acting sugar: _____ 1. If student able to swallow, give one of the following fast acting sugars: **10 grams** □____ glucose tablets □ 1/2 cup of juice or regular soft drink □ 2 teaspoons of honey □ 10 skittles □ 10 mL (2 teaspoons) or 2 packets of table sugar dissolved in water □ Other (ONLY if 10 grams are labelled on package): **OR 15 grams** □ ____ glucose tablets □ 3/4 cup of juice or regular soft drink □ 1 tablespoon of honey □ 15 skittles □ 15 mL (1 tablespoons) or 3 packets of table sugar dissolved in water □ Other (ONLY if 15 grams are labelled on package): 2. Contact designated emergency school staff person 3. Blood glucose should be retested in 15 minutes. Retreat as above if symptoms do not improve or if blood glucose remains below 4 mmol/L 4. Do not leave student unattended until blood glucose 4 mmol/L or above 5. Give an extra snack such as cheese and crackers if next planned meal/snack is not for 45 minutes.

MEDICAL ALERT – GIVING GLUCAGON FOR SEVERE LOW BLOOD GLUCOSE

SYMPTOMS	PLAN OF ACTION
□ Unconsciousness □ Having a seizure (or jerky movements) □ So uncooperative that you cannot give juice or sugar by mouth	□ Place on left side and maintain airway □ Call 911, then notify parents □ Manage a seizure: protect head, clear area of hard or sharp objects, guide arms and legs but do not forcibly restrain, do not put anything in mouth □ Administer glucagon

Medication	Dose & Route	Directions
Glucagon (GlucaGen or Lilly Glucagon) bottle **Frequency:** Emergency treatment for severe low blood glucose	0.5 mg = 0.5 ml. (for students 5 years of age and under) OR 1.0 mg =1.0 mL (for students 6 years of age and over) Give by injection: Intramuscular	□ Remove cap □ Inject liquid from syringe into dry powder □ Roll bottle gently to dissolve powder □ Inject into outer mid-thigh (may go through clothing) □ Once student is alert, give juice or fast acting sugar

Physicians Authorization:
Name: _____ *Signature:* _____ *Date:* _____

October 25, 2017

BOARD OF EDUCATION BURNABY SCHOOL DISTRICT 41

FORM B PEN #

DIABETES SUPPORT PLAN

Completed by Parent/Guardian Student Name:

LEVEL OF SUPPORT REQUIRED FOR STUDENTS NOT RECEIVING NSS DELEGATED CARE

Requires checking that task is done (child is proficient in task):	Requires reminding to complete:	
□ Blood glucose testing □ Carb counting/adding □ Administers insulin □ Eating on time if on NPH insulin □ Act based on BG result	□ Blood glucose testing □ Carb counting/adding □ Insulin administration □ Eating on time if on NPH insulin □ Act based on BG result	□ Student is completely independent

MEAL PLANNING: The maintenance of a proper balance of food, insulin and physical activity is important to achieving good blood glucose control in students with diabetes.

In circumstances when treats or classroom food is provided but not labeled, the student is to:
□ Call the parent for instructions □ Manage independently

BLOOD GLUCOSE TESTING: Students must be allowed to check blood glucose level and respond to the results in the classroom, at every school location or at any school activity. If preferred by the student, a private location to do blood glucose monitoring must be provided, unless low blood sugar is suspected.

Frequency of Testing: □ mid-morning □ lunchtime □ mid-afternoon □ before sport or exercise

□ With symptoms of hyper/hypoglycemia □ Before leaving school

Location of equipment: With student _____ In classroom _____

In office _____ Other _____

Time of day when low blood glucose is most likely to occur: _____
Instructions if student takes school bus home:

PHYSICAL ACTIVITY: Physical exercise can lower the blood glucose level. A source of fast-acting sugar should be within reach of the student at all times (see page 2 for more details). Blood glucose monitoring is often performed prior to exercise. Extra carbohydrates may need to be eaten based on the blood glucose level and the expected intensity of the exercise.

Comments:

INSULIN: All students with type 1 diabetes use insulin. Some students require insulin during the school day, most commonly before meals.

Is insulin required at school on a daily basis? Yes No

Insulin delivery system: □ Pump □ Pen □ Needle and syringe (at home or student fully independent)

Frequency of insulin administration:

DIABETES SUPPORT PLAN Student Name: _____

Parent/Guardian Authorization

The parent/guardian of the above named student must check the following information and sign this plan.

□ I authorize Burnaby School District staff trained in the administration of Glucagon to administer the designated treatment and to obtain suitable medical assistance in the case of an emergency.

□ I authorize Burnaby School District staff to follow the Diabetes Support Plan & Medical Alert Information Form as signed by the physician.

□ I have provided emergency sugars and snacks for the treatment of low blood sugar.

□ I have provided a glucometer and adequate supplies for the monitoring of blood sugar levels for my child.

□ I have provided a Glucagon kit for my child.

□ My child is aware of safe disposal of sharps and supplies.

□ If changes occur to my child's condition I will contact the school and provide revised information.

Your child's personal information is collected under the authority of the *School Act* and the *Freedom of Information and Protection Act.* The Board of Education may use your child's personal information for the purposes of:

- Health, safety, treatment and protection
- Emergency care and response

If you have any questions about the collection of your child's personal information, please contact the school principal directly. By signing this form, you give your consent to the Board of Education to disclose your child's personal information to the school staff and persons reasonably expected to have supervisory responsibility of school-aged students and preschool age children participating in early learning programs for the above purposes. This consent is valid and in effect until it is revoked in writing by you.

Parent/Guardian Signature: _____ Date Completed: _____

This agreement must be reviewed at the beginning of every school year and when changes occur.

Dates Reviewed by Parent/Guardian _____ _____ _____

Copies to: _____Parent(s)/Guardian(s) _____School Health Resource Binder (red binder)

_____Nursing Support Care Plan (if necessary) _____Student's Emergency Kit