School District 42

Type 1 Diabetes Action Plan and Medical Alert Information

Instructions: *This form is a communication tool for use by parents to share information with the school. Section B (Medical alert - treating mild to moderate low blood glucose) and Section C (Student Self-Management Plan) are <u>not</u> to be completed for students receiving Nursing Support Services Delegated Care.*

This form is to be completed by the parent or legal guardian and updated annually.
A copy of this form must accompany the student to the hospital.

A. EMERGENCY CONTACT INFORMATION				
Name of Student:			**Date of Birth;**	
School: **Grade:**			**Teacher/Division:**	
Care Card Number:			**Date of Plan:**	
CONTACT INFORMATION				
Parent/Guardian 1:	Name:			**Call First (circle which is applicable)**
Phone Numbers:	Cell:	Work:	Home:	Other:
Parent/Guardian 2:	Name:			**Call First (circle which is applicable)**
Phone Numbers:	Cell:	Work:	Home:	Other:
Other/Emergency:	Name: Able to advise on diabetes care: ☐ Yes ☐ No		Relationship:	
Phone Numbers:	Cell:	Work:	Home:	Other:
Family Physician:	Name:		No:	
Other Physician:	Name:		No.:	
Any known allergies:				
Have emergency supplies been provided in the event of a natural disaster? ☐ Yes ☐ No If *yes*, location of emergency supply of insulin:				
STUDENTS RECEIVING NSS DELEGATED CARE – SEE RED BINDER FOR CARE PLAN				

Parent *Signature*: _____

Parent *Printed* Name: _____

Date: _____

B. MEDICAL ALERT - TREATING MILD TO MODERATE LOW BLOOD GLUCOSE

NOTE: PROMPT ATTENTION CAN PREVENT SEVERE LOW BLOOD GLUCOSE

SYMPTOMS	TREATMENT FOR STUDENTS NEEDING ASSISTANCE (anyone can give sugar to a student):
☐ Shaky, sweaty ☐ Hungry ☐ Pale ☐ Dizzy ☐ Irritable ☐ Tired/sleepy ☐ Blurry vision ☐ Confused ☐ Poor coordination ☐ Difficulty speaking ☐ Headache ☐ Difficulty concentrating 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 tablespoon) 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 – 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 **if requested by parent***

***Instructions for the Administration of Glucagon, ONLY if requested by parent or legal guardian**

☐ Parent has requested administration of Glucagon. The parent has returned the Type 1 Diabetes Medical Administration form (signed by a physician) and has provided Glucagon. Glucagon is kept: _____

☐ *No* Glucagon to be given as requested by parent/guardian

Medication	Dose & Route	Directions
Glucagon (GlucaGen or Lilly Glucagon) 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) Given by injection: Intramuscular	• Remove cap • Inject liquid from syringe into dry powder bottle • Roll bottle gently to dissolve powder • Draw fluid dose back into the syringe • Inject into outer mid-thigh (may go through clothing) • Once student is alert, give juice or fast acting sugar

C. STUDENT SELF-MANAGEMENT PLAN

☐ Is receiving delegated care through NSS

☐ Self manages needs and is not receiving delegated care through NSS

SELF MONITORING

Student is proficient in testing, carb counting, administering insulin, eating on time if on NPH insulin and acting based on blood glucose result.

Additional information:

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.

Additional information:

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 glucose is suspected.

Additional information:

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.

Additional information:

INSULIN: All students with Type 1 Diabetes use insulin. Some students require insulin during the school day, most commonly before meals. **No student will have insulin administered by school staff unless under the care of NSS.**

Additional information:

D. AUTHORIZATION

I agree:

- To provide emergency sugars and snacks for the treatment of low blood sugar.
- To keep a glucometer and adequate supplies for the monitoring of blood sugar levels for my child.
- To provide Glucagon if I have requested administration of Glucagon at school. I have provided the school with a physician signed copy of the Type 1 Diabetes Medication Administration form.
- To provide my child with a medical alert bracelet/necklace.
- To contact the school and provide revised instructions if changes occur. I am aware I am required to update this information as needed and no less than annually.
- That my failure to do the above may result in an inability to implement timely emergency procedures for this potential life threatening condition.
- That the Public Health Nurse for the school will be informed of my child's condition and treatment and that the nurse may contact me as necessary.
- To authorize the staff of School District No. 42 and its agents, including volunteers, to execute the school's commitments as outlined within this plan.

I give consent for the identification of my child as a person with Type 1 Diabetes. I understand that this may include the display of pertinent information, including a picture of the child in strategic locations within the school. It is understood that the reason for this display is to enable the staff of School District No. 42 and its agents to be able to respond to potential emergencies in a timely fashion. It is clearly understood that student confidentiality will be maintained wherever possible.

I authorize the staff of School District No. 42 and its agents to administer the designated treatment and to obtain suitable medical assistance. I agree to assume all costs associated with the medical treatment and absolve the staff of School District No. 42 and the Maple Ridge-Pitt Meadows School Board of the responsibility for any adverse reactions resulting from the administration of the designated medication.

This agreement is valid from the date signed until revoked.

Parent/Guardian signature: _____ Date completed: _____

Principal's Signature: _____ Date completed: _____

Copies: ☐ **Parent(s)** ☐ ☐ **Student File** ☐ **Medical Alert Binder** ☐ **TTOC File**
☐ **Student Emergency Kit(s)** ☐ **Student Information System Inputted**

This Type 1 Diabetic Action Plan has been collaboratively developed by Public Health, Maple Ridge and School District No. 42. The information collected on this form is subject to and protected by the provisions of the Freedom of Information and Protection of Privacy Act.

Type 1 Diabetes Medication Administration Form

School District 42
Maple Ridge & Pitt Meadows
Learning Today, Leading Tomorrow

Instructions: *This form is updated annually to document physician approval regarding the following:*

- *Administration of Glucagon by school staff*
- *Administration of Insulin by school staff for a student not able to complete the task* ***(NSS Delegated Care.*** **No student can receive insulin from staff at school unless under the care of NSS).**
- *Supervision by school staff of a student self-administering insulin who is not yet fully independent in the task* ***(NSS Delegated Care)***

Student Name:_____ **Date of Birth:** _____

School:_____ **Care Card Number:** _____

Parent/Guardians' Name(s): _____

Home Phone:_____ **Cell Phone:** _____

Glucagon (GlucaGen® or Lilly Glucagon™)

For severe low blood glucose, given by intramuscular injection:
☐ 0.5 mg = 0.5 ml for students 5 years of age and under
☐ 1.0 mg = 1.0 ml for students 6 years of age and over

Insulin (rapid acting insulin only)

Insulin delivery device: ☐ insulin pump ☐insulin pen

Note: The following **cannot** be accommodated when insulin administration is being delegated to a school staff person via pump or pen:

- Overriding the calculated dose
- Entering an altered carbohydrate count for foods in order to change the insulin dose
- Changing the settings on the pump
- Deviating from the NSS Delegated Care Plan

For students using an insulin pen, insulin may be administered at lunchtime only (due to the inability to accurately calculate insulin on board). The method of calculating the dose is as follows:

☐ Bolus Calculator Sheet
☐ Variable dose insulin scale for blood glucose for consistent carbohydrates consumed
☐ InsuLinx® Meter

Parent/guardian authority to adjust insulin dose for Bolus Calculator Sheet or sliding scale:

☐ Yes ☐ No

For students using an insulin pump, insulin can be given if needed at recess, lunch and two hours after lunch (as there is an ability to know the insulin on board).

Physician Signature:_____ Date: _____

Physician Name:_____ Clinic Phone Number: _____