



SUDBURY CATHOLIC DISTRICT SCHOOL BOARD

Medical Conditions Package
for
Diabetes

PARENT/GUARDIAN

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Introduction:

This Diabetes Management Protocol addresses the components of Ministry of Education Policy/Program Memorandum #161 Supporting Children and Students with Prevalent Medical Conditions (Epilepsy/Seizure Disorder) in Schools.

ROLE of Parents/Guardians with School:

In order for School Staff to provide a safe and nurturing environment for students managing their diabetes are asked to:

- **Provide Proof of Diagnosis for your child which can be ONE of:**
 - A letter/note from the physician or specialist, OR
 - A copy/photocopy of the prescription, OR
 - A photocopy of the prescription from the medicine container, OR
 - A copy/photocopy of the Official Receipt of the medication from the pharmacist
- **COMPLETE and return the following forms found in this package:**
 - **STUDENT PLAN OF CARE**
 - Parents/Guardians of newly registered or newly diagnosed students shall create the Student Plan of Care in consultation with School Administration during the last week of August or as soon as possible to starting the school year. For students already registered, **the Student Plan of Care should be reviewed and/or updated annually and shared with the school, before the start of each school year.**
 - **CONSENT FORM TO CARRY AND ADMINISTER MEDICATION/DISCLOSE PERSONAL INFORMATION**
 - Form is completed by Parent/Guardian to carry and self-administer medication. Also includes consent to share life-threatening condition with pertinent individuals.

Please Note – Urgency of Having Completed Forms as Soon as Possible:

To act in the best interest of your child responding to a reaction, you are strongly encouraged to provide all relevant information and forms to manage your child's diabetes to the school principal in a timely manner. Failure to do so may place your child at unnecessary risk.

- **COMMUNICATE with School Administrator that your child requires professional health services within the school setting to assist with management protocols:**

Procedures

- Arrange with the principal to discuss.
- Complete an application form to the LHIN (Local Health Integration Network)
- A LHIN case manager will contact parent and principal and complete an assessment of the child's health care needs in the school setting.
- A multidisciplinary conference may be required to identify the needs at school and to determine eligibility for services.
- On admission, goals will be determined and a service plan developed to ensure the safest possible learning environment for your child.
- On occasion, there may be a waiting period for some services, and/or a lack of availability of service providers. In these circumstances, the LHIN will work with parents and school staff to develop a safe plan for the child.

- **UPDATE Changes of information: Emergency Contact, Medication, Medical Diagnosis:**

Parents are responsible to inform School administration of any changes to contact information, medication or medical condition diagnosis as soon as reasonable possible. Forms can be accessed through the school office.

NOTE: Changes to your child's diagnosis must be accompanied by a note/letter from your child's physician indicating the change.

Please Note: Board employees are not trained health professionals

Prevention

- **COMMUNICATE, when your child is transitioning to a new school**

You should ask for a most recent copy of your child's Diabetes Student Plan of Care. You are requested to update the form with recent medical and contact information and to provide the completed form to the receiving school administrator/designate during a transition meeting.

PROVIDE a constant supply of fast acting sugar, to prevent and treat low blood sugar.

- **PROVIDE, when appropriate, an extra snack** (e.g. trips)
- **PROVIDE a clearly labelled (student name, address) container** which includes blood glucose monitoring items and insulin items and medication.
- **CONSIDER providing a MedicAlert bracelet or necklace for your child,** and discuss the importance of wearing it. The form can be obtained by calling 1-800-668-1507 or visit www.medicalert.ca

Responsibilities of Parent/Guardian with their Child:

Communicate the following information and responsibilities to your child in managing their diabetes. Review with your child when appropriate.

- Provide age appropriate understanding of their diabetes, how to recognize the symptoms of a low blood sugar and high blood sugar and how to take age appropriate action to treat their symptoms.
- Provide age appropriate information on how to administer the blood sugar monitoring system, blood testing, insulin injection, safe disposal of lancets and needles, how to manage and use appropriately the insulin pump (e.g. administering a bolus dose).
- The importance of carrying/having immediate access to their blood sugar testing kit, fast acting sugar and insulin injection apparatus at all times.
- Guide and encourage your child to self-management and self-advocacy.
- Inform your child that when they are having an attack, never remove themselves to a secluded area or go off to be by themselves (e.g. washroom) and to tell a teacher, staff member or a classmate when feeling a reaction or when feeling unwell.
- The importance of eating all and only what parents/guardians have provided.
- Inform, check and review when necessary with their child the location of their blood sugar testing kit, insulin injection apparatus and fast acting sugar during the school day and at school sponsored activities.
- Remind the child, prior to the child leaving for school, to check that the container for carrying (e.g. 'fanny pack', purse) contains the blood sugar testing kit, insulin apparatus and fast acting sugar.

- Talk to their friends about their diabetes and let them know how they can help them.
- Communicate with parents/school staff if they are facing challenges related to their diabetes, including any and all teasing, bullying, threats or any other concerns they have.
- Consider providing Medical Alert identification for your child (e.g. bracelet or necklace). The form can be obtained by calling 1-800-668-1507 or visit www.medicalalert.ca

Responsibilities of Students (where appropriate)

- Advocate for their personal safety and well-being
- Participate in the development and review of Plan of Care
- Carry out daily or routine self-management of their medical conditions as described in their Plan of Care
- Set goals on an ongoing basis for self-management of their medical condition in conjunction with their parents and healthcare professional
- Recognize their symptoms of a low blood sugar and high blood sugar and how to take age appropriate action to treat the symptoms.
- Eat all only what parents/guardians have approved.
- Check prior to leaving home that they have their blood sugar testing kit, insulin apparatus and fast acting sugar.
- Take responsibility for carrying their blood sugar testing kit and insulin injection apparatus and fast acting sugar during the school day and at school sponsored activities.
- Check that blood sugar testing kit, insulin injecting apparatus and fast acting sugar is always accessible to their location.
- Know, in age appropriate ways, how to administer the blood sugar monitoring system, blood testing, insulin injection and safe disposal of lancets and needles, how to manage and use appropriately the insulin pump.
- Promptly inform an adult that they have diabetes as soon as symptoms appear or when experiencing a general feeling of 'un-wellness'.
- Never isolate themselves when checking blood sugar or feeling unwell.
- Communicate with parents/school staff that they are facing challenges related to their diabetes, including any, and all, teasing, bullying, threats or any other concerns they have.
- Wear/carry medical alert and identification when parent/guardian deems appropriate.

SCHOOL FORMS

• STUDENT PLAN OF CARE: DIABETES

- To identify your child to others, this form will be created by yourself and the school team. The School Administrator will share with appropriate school staff and post as necessary.
- The Transportation Consortium's Medical Information Form must also be filled in by a medical professional <http://www.businfo.ca/en/pdf/forms/F-M04-404%20-%20Medical%20Note.pdf>

• AT-A-GLANCE MEDICAL CONDITION IDENTIFICATION

To identify your child to others, an At-A-Glance document is created, by the School Administrator/Designate, which includes the student's name, grade, picture, and medical condition only and is only posted in pertinent staff areas (i.e. staff room).

- **CONSENT FORM TO CARRY AND ADMINISTER MEDICATION/DISCLOSE PERSONAL INFORMATION**
 - Form is completed by Parent/Guardian to carry and self-administer medication. Also includes consent to share life-threatening condition with pertinent individuals.

PREVALENT MEDICAL CONDITION – DIABETES

Plan of Care

STUDENT INFORMATION

Student Name _____

Date of Birth _____

Ontario Ed. # _____

Age _____

Grade _____

Teacher(s) _____

Student Photo

EMERGENCY CONTACTS (LIST IN PRIORITY)

NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

DIABETES SUPPORTS

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

Method of home-school communication: _____

Any other medical condition or allergy? _____

DAILY/ROUTINE DIABETES MANAGEMENT

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
<p>BLOOD GLUCOSE MONITORING</p> <p><input type="checkbox"/> Student requires trained individual to check BG/ read meter.</p> <p><input type="checkbox"/> Student needs supervision to check BG/ read meter.</p> <p><input type="checkbox"/> Student can independently check BG/ read meter.</p> <p><input type="checkbox"/> Student has continuous glucose monitor (CGM)</p> <p>* Students should be able to check blood glucose anytime, anyplace, respecting their preference for privacy.</p>	<p>Target Blood Glucose Range _____</p> <p>Time(s) to check BG: _____</p> <p>_____</p> <p>Contact Parent(s)/Guardian(s) if BG is: _____</p> <p>Parent(s)/Guardian(s) Responsibilities: _____</p> <p>_____</p> <p>School Responsibilities: _____</p> <p>_____</p> <p>Student Responsibilities: _____</p>
<p>NUTRITION BREAKS</p> <p><input type="checkbox"/> Student requires supervision during meal times to ensure completion.</p> <p><input type="checkbox"/> Student can independently manage his/her food intake.</p> <p>* 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.</p>	<p>Recommended time(s) for meals/snacks: _____</p> <p>Parent(s)/Guardian(s) Responsibilities: _____</p> <p>_____</p> <p>School Responsibilities: _____</p> <p>_____</p> <p>Student Responsibilities: _____</p> <p>Special instructions for meal days/ special events: _____</p> <p>_____</p>

ROUTINE	ACTION (CONTINUED)
<p>INSULIN</p> <p><input type="checkbox"/> Student does not take insulin at school.</p> <p><input type="checkbox"/> Student takes insulin at school by:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Injection</p> <p style="margin-left: 20px;"><input type="checkbox"/> Pump</p> <p><input type="checkbox"/> Insulin is given by:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Student</p> <p style="margin-left: 20px;"><input type="checkbox"/> Student with supervision</p> <p style="margin-left: 20px;"><input type="checkbox"/> Parent(s)/Guardian(s)</p> <p style="margin-left: 20px;"><input type="checkbox"/> Trained Individual</p> <p>* All students with Type 1 diabetes use insulin. Some students will require insulin during the school day, typically before meal/nutrition breaks.</p>	<p>Location of insulin: _____</p> <p>_____</p> <p>Required times for insulin: _____</p> <p><input type="checkbox"/> Before school: <input type="checkbox"/> Morning Break:</p> <p><input type="checkbox"/> Lunch Break: <input type="checkbox"/> Afternoon Break:</p> <p><input type="checkbox"/> Other (Specify): _____</p> <p>Parent(s)/Guardian(s) responsibilities: _____</p> <p>School Responsibilities: _____</p> <p>Student Responsibilities: _____</p> <p>Additional Comments: _____</p>
<p>ACTIVITY PLAN</p> <p>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 student's reach.</p>	<p>Please indicate what this student must do prior to physical activity to help prevent low blood sugar:</p> <p>1. Before activity: _____</p> <p>2. During activity: _____</p> <p>3. After activity: _____</p> <p>Parent(s)/Guardian(s) Responsibilities: _____</p> <p>School Responsibilities: _____</p> <p>Student Responsibilities: _____</p> <p>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)</p>

ROUTINE	ACTION (CONTINUED)
<p>DIABETES MANAGEMENT KIT</p> <p>Parents 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.</p>	<p>Kits will be available in different locations but will include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Blood Glucose meter, BG test strips, and lancets <input type="checkbox"/> Insulin and insulin pen and supplies. <input type="checkbox"/> Source of fast-acting sugar (e.g. juice, candy, glucose tabs.) <input type="checkbox"/> Carbohydrate containing snacks <input type="checkbox"/> Other (Please list) _____ <p>_____</p> <p>Location of Kit: _____</p>
<p>SPECIAL NEEDS</p> <p>A student with special considerations may require more assistance than outlined in this plan.</p>	<p>Comments:</p>

EMERGENCY PROCEDURES

HYPOGLYCEMIA – LOW BLOOD GLUCOSE (4 mmol/L or less)

DO NOT LEAVE STUDENT UNATTENDED

Usual symptoms of Hypoglycemia for my child are:

- | | | | |
|---|--|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Shaky | <input type="checkbox"/> Irritable/Grouchy | <input type="checkbox"/> Dizzy | <input type="checkbox"/> Trembling |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Headache | <input type="checkbox"/> Hungry | <input type="checkbox"/> Weak/Fatigue |
| <input type="checkbox"/> Pale | <input type="checkbox"/> Confused | <input type="checkbox"/> 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 unresponsive)

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 emergency medical personnel arrives.
3. 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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Extreme Thirst | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Hungry | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> Warm, Flushed Skin | <input type="checkbox"/> Irritability | <input type="checkbox"/> 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)

- | | | |
|---|-----------------------------------|--|
| <input type="checkbox"/> Rapid, Shallow Breathing | <input type="checkbox"/> Vomiting | <input type="checkbox"/> 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.

PLAN

This plan remains in effect for the 20__ – 20__ school year without change and will be reviewed on or before: _____. (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).

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

Date: _____

Student: _____
Signature

Date: _____

Principal: _____
Signature

Date: _____

PLAN REVIEW

Where there is no change in the child's condition or treatment strategy from the previous year(s), parents may authorize continuation of the protocol with initials below.

☐ There has been no change in condition or treatment strategy from previous year. Parent initial: _____

Date: _____

☐ There has been no change in condition or treatment strategy from previous year. Parent initial: _____

Date: _____

☐ There has been no change in condition or treatment strategy from previous year. Parent initial: _____

Date: _____

**CONSENT FORM
TO CARRY AND ADMINISTER MEDICATION/DISCLOSE PERSONAL INFORMATION**

TO BE SIGNED BY PARENT/GUARDIAN UNLESS THE STUDENT IS 18 YEARS OF AGE OR OLDER

ADMINISTRATION OF MEDICATION

In the event of my child _____ experiencing a medical emergency, I consent to the administration of Fast Acting Sugar (specify type of medication) by an employee of the Sudbury Catholic District School Board as prescribed by the physician and outlined in the Emergency Procedures of the Prevalent Medical Conditions Policy/Administrative Procedure.

PLEASE PRINT

Student's Name: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Signature of Student (if 18 or older): _____

Class/Teachers' Names:

Date: _____

Date: _____

MAINTENANCE OF MEDICATION

I understand that it is the responsibility of my child _____ to carry _____ (specify type of medication) on his/her person.

PLEASE PRINT

Student's Name: _____

Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Signature of Student (if 18 or older): _____

Name of Physician: _____

Class/Teachers' Names:

Date: _____

Date: _____

Contact # _____

COLLECTION, DISCLOSURE AND USE OF PERSONAL INFORMATION

Authorization for the collection and maintenance of the personal information recorded on the Prevalent Medical Conditions form is the Municipal Freedom of Information and the Protection of Privacy Act. Users of this information should be directed by the principal of the school.

OPTIONAL:

Additionally, I further consent to the disclosure and use of the personal information collected herein to persons, including persons who are not the employees of the Sudbury Catholic District School Board through the posting of photographs and medical information of my child (Plan of Care/Emergency Procedures) in the following key locations:

<input type="checkbox"/> Classroom	<input type="checkbox"/> Staffroom	<input type="checkbox"/> Lunchroom
<input type="checkbox"/> Office	<input type="checkbox"/> Gym	<input type="checkbox"/> Learning Commons/Library
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Other: _____

and through the provision of personal information contained herein to the following persons who are not employees of the Board: please check (✓) all applicable boxes

<input type="checkbox"/> Food Service Providers	<input type="checkbox"/> Child Care Providers
<input type="checkbox"/> School Volunteers in regular direct contact with child	<input type="checkbox"/> Other: _____

Signature of Parent/Guardian: _____	Date: _____
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Signature of Student (if 18 or older): _____	Date: _____
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Signature of Principal: _____	Date: _____
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We release the Sudbury Catholic District School Board, its employees and agents from any and all liability for loss, damage or injury, howsoever caused to my/our child's person, or property, or to me/us as a consequence, arising from administering the interventions, failing to correctly administer the interventions and/or failing to administer any intervention listed in Diabetes Student Plan of Care.

Signature of Parent/Guardian: _____	Date: _____
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Signature of Student (if 18 or older): _____	Date: _____
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PLEASE NOTE THIS CONSENT EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR

This information is collected pursuant to s. 170 and s.265(1)i) of the Education Act, R.S.O. 1990, c. E-2 and s.28(2), 29, 30, 31,32 and 33 of the Municipal Freedom of Information and Protection of Privacy act, R.S.O. 1990, c. M-56: and the Personal Health Information Protection Act, 2004, S.O. 2004, c.3, Sch. A.

If you have any questions regarding your child's personal information, please contact the Principal of your child's school.

AT-A-GLANCE Medical Condition IDENTIFICATION

Student Name	Grade	Medical Condition	Picture (If available)