



OCDSB 963: PLAN OF CARE FOR STUDENTS WITH DIABETES

(References: [P.108.SCO](#), [PR.548.SCO](#), [PR.547.SCO](#), and [PR.632.SCO](#))

The information on this form is collected annually and deemed valid until August 31 of each school year.

Student Information (Attach a recent photo of student)

- Student Name (first, middle, last): _____
- Student Date of Birth: _____
- School Name: _____
- Grade: _____
- Student Number: _____
- Teacher Name: _____

Parent/Guardian Information (required if student is under 18 years of age)

- Parent/Guardian First and Last Name : _____
- Home Phone number: _____
- Parent Email Address: _____

Emergency Contacts (Please list in order of priority)

Name	Relationship	Daytime Phone	Alternate Phone	Email
1.				
2.				
3.				

Primary Healthcare Provider Information

- Name: _____
- Telephone Number: _____
- Profession/Role: _____

Diabetes Specialist Information

Same as Primary Healthcare Provider.

Different from Primary Healthcare Provider (Complete the following information)

- Name: _____
- Telephone Number: _____
- Profession/Role:

Physician

Nurse Practitioner

Registered Nurse

Pharmacist

Respiratory Therapist

Certified Respiratory Educator

Certified Asthma Educator

Other Please specify: _____

I/We authorize the school staff to contact the above health care provider as required to attend to the well-being of the student.

Please attach the most recent, original instructions, prescriptions, and labels pertaining to each medication. Date of prescription/notes must be captured.

Daily Management Procedures

BLOOD GLUCOSE (BG) MONITORING

Student requires trained staff 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)

Please check appropriate routine BG checking times

Balanced Day

Before 1st Nutrition Break

Before 2nd Nutrition Break

Regular Day

Before Morning Break

Before Lunch

Before Afternoon Break

Before getting on bus

Before Activity/PE class

Field trips

When showing signs of low blood glucose

When showing signs of high blood glucose

Other: _____

Optimal BG Range: _____

Contact Parent/guardian if BG is: _____
Method of Communication

Phone Call

Email

Other. Please specify: _____

NUTRITION BREAKS

Student requires supervision during meal times to ensure completion.

Student can independently manage their food intake.

- **Recommended time(s) for meals/snacks:** _____
- **Special instructions for special events:** _____

INSULIN

Student does not take insulin at school. Please proceed with the ACTIVITY PLAN section.

Student takes insulin at school. Please complete the following questions.

Insulin is given by:

Student

Student with supervision

Parent/Guardian

Other: _____

Insulin required at the following times:

Balanced Day -Before 1st Nutrition Break

Balanced Day - Before 2nd Nutrition Break

Regular Day - Before Morning Break

Regular Day - Before Lunch

Regular Day - Before Afternoon Break

Other: _____

Student takes insulin at school by:

Injection. **OCDSB staff does not provide insulin injections.**

Pump. Please answer the following questions:

- **Always use the insulin pump bolus calculator:**

Yes

No

- **Blood glucose must be checked before the child eats and will**

(check one)

Be sent to the pump by the meter

Be entered into the pump

ACTIVITY PLAN

Please indicate what the student must do to help prevent a low BG (i.e. take food or test)

- Before exercise: _____
- During exercise: _____
- After exercise: _____

DIABETES MANAGEMENT KIT

The kit will include (check all that apply):

Fast-acting sugar, carbohydrate snack in emergency

Gel or Icing sugar for Severe low BG

Blood glucose meter and test strips, lancets.

Insulin pen, pen needles or syringe, insulin (in case of pump failure).

Contact numbers

Do you authorize the student to carry their Diabetes Management Kit at all times?

Yes. Location of Kit on student: _____

No. Location of Kit elsewhere: _____

Please specify location of **backup Kit** in school: _____

Storage Cautions (if any): _____

Disposal Instructions: _____

I/We acknowledge that it is my/our responsibility to submit enough backup medication and medical supplies to school and to track the expiration date.

OTHER REQUIRED ACCOMMODATION

Emergency Management Procedures

MANAGING LOW BLOOD GLUCOSE (HYPOGLYCEMIA) _____ mmol/L or less

Usual symptoms of low blood glucose for this student are:

Shaky

Irritable/grouchy

Dizzy

Sweating

Headache

Blurred vision

Hungry

Weak/fatigue

Fast heartbeat

Pale

Anxious

Other: _____

Specific Course of Action for Hypoglycemia:

Specific Course of Action for Severe Hypoglycemia (student is unconscious/
unresponsive): _____

MANAGING HIGH BLOOD GLUCOSE (HYPERGLYCEMIA) _____ mmol/L or higher

Usual symptoms of high blood glucose for this student are:

Extreme thirst

Excessive voiding

Headache

Hungry

Abdominal pain

Blurred vision

Warm, flushed skin

Irritability

Other _____

Specific Course of Action: _____

Symptoms of Severe/dangerous high blood glucose for this child are:

Rapid, shallow breathing

Vomiting

Fruity breath

Specific Course of Action: _____

Parent(s)/Guardian(s) Authorization to Administer Medication

The administration of medication involves certain elements of risk, including, but not limited to illness, adverse reactions or other complications. Reactions caused by the administration of any medication can occur without fault on any party; the student, or the OCDSB or its employees or agents. By requesting and consenting to the administration of medication by an employee of the OCDSB, or by authorizing the self-administration of medication by the student, you are assuming any associated risks.

In life-threatening emergencies, staff will administer prescribed medication to students “in loco parentis”, not as healthcare professionals.

I/We authorize the OCDSB staff to administer prescribed medication to the student as prescribed. I/We understand that OCDSB staff is not medically trained to administer medication and bear sole responsibility for any adverse reaction that might occur following the administration of medication.

The student is capable of administering their own medication. I/We bear sole responsibility for any adverse reaction that might occur following the self-administration of medication.

Consent to Release Information

Does the student use OSTA bus on a regular basis?

Yes. A copy of the Student Care Plan will be shared with OSTA.

No.

I confirm that the information herein is accurate and up to date. I understand that I must re-submit this form in case of any changes to the student's medication, condition, level of independence, or treatment plan.

I/We give consent for the school to share this Plan of Care as necessary with individuals in direct contact with the student to attend to their well-being and medical needs at school and during school activities. This may include school and office staff, occasional staff, OSTA, contracted bus operators and bus drivers, before- and after-school program staff. This plan will be posted in identified areas of the school for emergency response purposes.

Parent(s)/guardian(s)/Adult Student Name: _____

Parent(s)/guardian(s)/Adult Student signature: _____

Date: _____

The personal information of this form is collected under the authority of the Education Act (RSO. 1990 c.E.2) and in accordance with the Municipal Freedom of Information and Protection of Privacy Act (RSO. 1990 c.M56), as amended. It will be used to establish the Ontario Student Record [OSR] and for student and education related purposes such as registration, administration, communication, collection of fees, data reporting, and Student Transportation Services. In addition, the information may be used or disclosed to comply with legislation, for compelling circumstances affecting health and safety or discipline, as required in circumstances related to allow enforcement matters, and with third parties in accordance with established service agreements or in accordance with any other Act. Questions or concerns should be directed to the school principal or the Board's Freedom of Information Coordinator, Ottawa-Carleton District School Board, 133 Greenbank Road, Ottawa, Ontario, K2H 6L3, Telephone 613-596-8211 ext. 8607.