Appendix A

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

To Be Completed by Parent/Guardian/Adult Student Annually
(Please Print or Type)

Student's Name: _____ Birthdate: _____

I acknowledge that the staff of the Hamilton-Wentworth Catholic District School Board are not health care professionals and have no more information about the medical condition of my/our child than that which has been provided to them in writing by myself/ourselves or by my/our child's physician and/or nurse practitioner. They are not experts in recognizing the symptoms of my/our child's medical condition or in treating it.

To the extent possible, my/our child has been trained by me/us and by health care professionals to recognize her/his own need for intervention/medication and to respond to the need by requesting intervention or by self-administering the appropriate medication.

Where feasible, my/our child is responsible for the necessary medication and equipment to address the diabetic condition.

I/we are responsible for ensuring that :

- O a medical document is provided to the school outlining my/our child's diagnosis of Diabetes;
- O all medical updates/changes or emergency information will be provided for the school staff immediately;
- O there is a supply of fast-acting sugar (oral glucose/orange juice, etc.) at the school, provided by me/us;
- O **two (2) BAQSIMI tubes, if prescribed by physician or nurse practitioner;**
- O blood glucose monitoring items are contained in a safe container, labelled with my/our child's name, for transport and storage in the classroom;
- O insulin injection items are contained in a safe container, labelled with my/our child's name; and,
- O the teacher has been informed of the incidents relating to diabetes about which I/we wish to be informed.

The specific incidents related to diabetes about which I/we would like to be informed are:

O _____

O _____

Neither the Principal nor the staff of the school is responsible for:

- providing a supply of fast-acting sugar (oral glucose, orange juice, etc.);
- storing insulin over night;
- reading blood glucose monitors; or
- administering insulin injections.

In the event of an emergency (severe hypoglycemic incident), **I/we authorize the school staff to administer BAQSIMI and obtain emergency services as are necessary.** I/We agree to assume responsibility for all costs associated with the medical intervention.

Parent/Guardian/Adult Student Name: _____

Parent/Guardian/Adult Student Signature: _____

Date: Month _____ Day ___ Year _____

Principal's Signature: _____

Posting of Photographs and Individual Diabetes Plan of Care

I consent to the posting of colour photographs of my child _____

and of medical information related to my child (Individual Diabetes Action Plan) in locations deemed appropriate by school staff, which may include the classroom, lunchroom, main office, resource room, school bus, staff room and other locations.

I consent to the posting of colour photographs of myself _____

and of medical information related to my Individual Diabetes Action Plan in locations deemed appropriate by school staff, which may include the classroom, lunchroom, main office, resource room, school bus, staff room and other locations.

Parent/Guardian/Adult Student Name: _____

Parent/Guardian/Adult Student Signature: _____

Date: Month _____ Day ___ Year _____

Principal's Signature: _____

Consent to the Development of an Individual Diabetes Plan of Care

I consent to the development of an Individual Diabetes Plan of Care for my child/myself_____. This plan will outline the emergency steps that shall be taken if my child /I experiences a Diabetic reaction on school property or during a school or school board sponsored event.

The information contained in this plan will be shared, as necessary, with relevant individuals for my child's/my protection and well-being.

Individuals with whom the plan may be shared include, but are not limited to classroom teachers, occasional teachers, itinerant teachers, educational assistants, coaches, other school staff and school bus drivers.

Parent/Guardian/Adult Student Name: _____

Parent/Guardian/Adult Student Signature: _____

Date: Month _____ Day ___ Year _____

Principal's Signature: _____

SS-02-57-INT (Copy to Documentation File of OSR and Student Medical File in main office)

This information is collected, retained, accessed and otherwise used in accordance with 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. 204, c. 3, Sched. A.

Appendix B

HAMILTON-WENTWORTH CATHOLIC DISTRICT SCHOOL BOARD

INDIVIDUAL DIABETES PLAN OF CARE		
STUDENT INFORMATION		
Student Name _____	**Date of Birth** _____	**Student Colour Photo**
Grade _____	**Teacher(s)**_____	

EMERGENCY CONTACTS (LIST IN PRIORITY)			
NAME	RELATIONSHIP	DAYTIME PHONE	ALTERNATE PHONE
1.			
2.			
3.			

TYPE 1 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 TYPE 1 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
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 his/her food intake. ✸ 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.	Recommended time(s) for meals/snacks:_____ Parent(s)/Guardian(s) Responsibilities:_____ _____ School Responsibilities:_____ _____ Student Responsibilities:_____ Special instructions for meal days/ special events:_____ _____

ROUTINE	ACTION (CONTINUED)
INSULIN ❒ Student does not take insulin at school. ❒ Student takes insulin at school by: ❒ Injection ❒ Pump ❒ Insulin is given by: ❒ Student ❒ Student with supervision ❒ Parent(s)/Guardian(s) ❒ Trained Individual ✸ 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 Parents/Guardians/Adult Student 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/guardians/adult students when supplies are low.	Kits will be available in different locations but will include: ❒ **BAQSIMI** ❒ 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:

EMERGENCY PROCEDURES

HYPOGLYCEMIA – LOW BLOOD GLUCOSE
(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, 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. **Administer BAQSIMI.**
3. Call 9-1-1. Do not give food or drink (choking hazard). Supervise student until EMS arrives.
4. Contact parent(s)/guardian(s) or emergency contact

Refer to Appendix J for the Board Policy concerning Diabetes

HYPERGLYCEMIA — HIGH BLOOD GLOCOSE
(14 MMOL/L OR ABOVE)

Usual symptoms of hyperglycemia for my child/myself 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/guardian 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

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.

AUTHORIZATION/PLAN REVIEW			
INDIVIDUALS WITH WHOM THIS PLAN OF CARE IS TO BE SHARED			
		Yes (Please Initial for each)	No (Please Initial for each)
We, the Parents/Guardians/ Adult Student request the posting of this Individual Plan of Care in the:	School Staff Room		
	Elementary Homeroom Classroom		
	School Main Office		
We the Parents/Guardians/Adult Student request the sharing of this plan with individuals which include, but are not limited to classroom teachers, occasional teachers, itinerant teachers, educational assistants, coaches, other school staff, and school bus drivers.			
We the Parents/Guardians/ Adult Student request the sharing of information on signs and symptoms of Diabetes with students in the classroom.			
We, the Parents/Guardians request the sharing of this Individual Plan of Care with the Before and After-School Program.			

TRANSPORTATION		
School Bus Driver/Route # (If Applicable)	□ New Plan of Care	□Updated Plan of Care

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)/adult student'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):	Date:
Adult Student:	Date:
Principal:	Date: