New Nouveau Brunswick

DIABETES MANAGEMENT AND EMERGENCY PLAN
SCHOOL YEAR 2_____-2_____

PART I - STUDENT INFORMATION

Name of Student:_______________________________
Date of Birth:_______________________
year / month / day

Medicare Number:_______________________________
School:_______________________________
Home Room Teacher:_______________________________
Designated Staff:_______________________________
____
____

Photo
if provided by parent

Contact information

Mother/Guardian:_________________________
Telephone: Home_______________Work___________________
Cell_______________

Father/Guardian:_________________________
Telephone: Home_______________Work___________________
Cell_______________

Student's Physician:_______________________
Telephone:_________________________

Other/Emergency contact:
Name:_____________________________Relationship:_________________________
Telephone: Home_______________Work___________________Cell_______________

Notify parents/guardian or emergency contact in the following situations:_________________________
____
____

Any other conditions that may affect the treatment of your child:______________________________
____

My child is able to manage his/her diabetic care independently and does not require any special care from the school.

☐ **Yes** ☐ **No**

If "Yes", go directly to PART III.

PART II - DIABETES MANAGEMENT PLAN *(if applicable)*

Blood Glucose Monitoring

Target range is:__________________

Usual time to check blood glucose:____

Other times to check blood glucose (i.e. before/after exercise): ____________________________

My child can perform his/her own blood glucose check. ☐ Yes ☐ No

Parent's responsibilities:____

School's responsibilities:____

Student's responsibilities:____

Additional information:____

Insulin Injection

For students with insulin syringes/pen:

My child can give own injection. ☐ Yes ☐ No
My child can determine correct amount of insulin. ☐ Yes ☐ No

For students with an insulin pump:

My child can calculate and administer correct dose. ☐ Yes ☐ No

Usual dose:____________________________________

Parent's responsibilities:____

School's responsibilities:____

Student's responsibilities:____

Additional information:____

Food Management

Regular time for meal and snack: ______________________

My child can count carbohydrates. ☐ Yes ☐ No

Parent's responsibilities: ______________________

School's responsibilities: ______________________

Student's responsibilities: ______________________

Instructions when food is provided to the class: ______________________

Additional information: ______________________

Diabetes Management Kit

Supplies to be provided by parents and kept at school:

- ☐ Blood glucose meters, test strips, and batteries.
- ☐ Insulin vials and syringes / or insulin pump supplies / or insulin pen and supplies.
- ☐ Fast-acting source of glucose.
- ☐ Carbohydrate containing snack (e.g. crackers and cheese).
- ☐ Glucagon emergency kit.
- ☐ A backup supply of fast-acting sugar.

Kit / Medication Management: ______________________

Special Events/Other

PART III - EMERGENCY PROCEDURES

Hypoglycemia (Low Blood Sugar)

Usual symptoms of hypoglycemia: ______________________________

Treatment of hypoglycemia: ______________________________

Hyperglycemia (High Blood Sugar)

Usual symptoms of hyperglycemia: ______________________________

Treatment of hyperglycemia: ______________________________

Glucagon

In case of an emergency I agree ______________________ (name of the student) **is to receive a Glucagon injection.** ☐ Yes ☐ No

If yes, weight: __________ Glucagon dosage ☐ 1/2 syringe
☐ entire syringe

PART IV - DESIGNATED SCHOOL PERSONNEL

The personnel listed below have received the necessary training to assist with the diabetes management and emergency intervention described above.

Name	Title

I have verified the instruction concerning ongoing diabetes management and emergency interventions provided to the persons above for the care of this student and find it acceptable.

Diabetes Educator/Health Professional: ______________________ (Signature)

Date: ______________ (year / month / day)

Title: ______________________

PART V - SIGN-OFF

I have read and understand the *Diabetes Management and Emergency Plan* and agree to the care described in this plan and the sharing of information relevant to the service requested with those who must know in order to provide the service.

Student (16 years and older): ______________________ Date: __________
signature year / month / day

I hereby request and authorize school personnel to provide the care described above to my child. I understand the designated persons have no medical qualifications and will perform the requested service in good faith and within the scope of the training received in accordance with this agreement.

In the event of an emergency, I authorize school personnel to administer the medication specified in this agreement and provided by me, and to obtain suitable medical assistance. I agree to assume responsibility for all costs associated with medical treatment and transportation.

I hereby acknowledge my responsibilities, as set out in this agreement, in Policy 704 - *Health Support Services* and the *Handbook for Type 1 Diabetes Management in Schools* and agree to carry these out to the best of my ability.

I agree to notify the school in writing of any changes to the information provided on this form.

I agree that the information provided on this form will be shared on a need-to-know basis with anyone who will be involved in the care of my child on behalf of the school.

I agree to have relevant information about my child's health/medical condition available in strategic areas of the school (e.g. classroom, kitchen, principal's office, staff room) to assist in providing emergency services to my child. I will provide a photo of my child for this purpose. ☐ Yes ☐ No

I agree that the principal or his/her designate may contact my child's physician in the event of a medical emergency or should he/she require clarification about the school's responsibilities as set out in this agreement. ☐ Yes ☐ No

Parent/Guardian: ______________________ Date: __________
signature year / month / day

I hereby acknowledge and accept my responsibilities and those of my staff, as set out in this agreement.

Principal: ______________________ Date: __________
signature year / month / day

The care described in this plan is essential and must be provided during school hours. ☐ Yes ☐ No

I have reviewed the *Diabetes Management and Emergency Plan* for ______________________
name of the student
and feel it is appropriate for his/her needs.

Diabetes Educator or Physician: ______________________ Date: __________
signature year / month / day

ANNUAL REVIEW

Note: if the requirements of the service requested have changed, complete a new *Diabetes Management and Emergency Plan*. If there are no changes, use this sign-off sheet to confirm the plan has been reviewed with the parent.

This plan remains in effect for the 2_____-2_____school year without change.

Parent/Guardian: ________________________ (signature) Date:__________ (year / month / day)

Principal: ________________________ (signature) Date:__________ (year / month / day)

This plan remains in effect for the 2_____-2_____school year without change.

Parent/Guardian: ________________________ (signature) Date:__________ (year / month / day)

Principal: ________________________ (signature) Date:__________ (year / month / day)

This plan remains in effect for the 2_____-2_____school year without change.

Parent/Guardian: ________________________ (signature) Date:__________ (year / month / day)

Principal: ________________________ (signature) Date:__________ (year / month / day)

This plan remains in effect for the 2_____-2_____school year without change.

Parent/Guardian: ________________________ (signature) Date:__________ (year / month / day)

Principal: ________________________ (signature) Date:__________ (year / month / day)

This plan remains in effect for the 2_____-2_____school year without change.

Parent/Guardian: ________________________ (signature) Date:__________ (year / month / day)

Principal: ________________________ (signature) Date:__________ (year / month / day)

CHILD'S NAME ____________________________

Teacher ____________________

Date of Birth:

Epipen Syringe Expires: ____________________

Dr.: ____________________________________

Medicare # ________________________________

Medic Alert Bracelet - Yes / No

Emergency Tele: Mother: ____________________)

: ____________________) + 911

Father : ____________________)

SEVERE HEALTH PROBLEMS / ALLERGIES:

Possible Causes Signs & Symptoms Action

____

____

____

____

____

OTHER ALLERGIES / HEALTH PROBLEMS

Possible Causes Signs & Symptoms Action

____

____

____

____

Location of "Medication": ____
(Epipen / other medication)

Policy 704 (Policy for Providing Health Support Services in Public Schools) states the following:

It is the responsibility of the parent/guardian to "Ensure that a student with conditions like severe allergies, asthma, diabetes or any other life-threatening conditions carries, every day, an EpiPen® or any other prescribed essential medication on his/her person (usually kept around the student's waist in a carrying pouch). School personnel should not be expected to search for proper medication in responding to an emergency situation".

Parent's Signature: ______________________________

Date: ____________________