

Appendices:

Diabetes Support Plan and Medical Alert Information

Instructions: This form is a communication tool for use by parents to share information with the school. Students who are receiving Nursing Support Services (NSS) Delegated Care do not need to complete page 3. This form does NOT need to be completed by Diabetes Clinic staff, Nursing Support Service Coordinators or Public Health Nurses.

Name of Student:		Date of Birth:		
School:	Grade:	Teacher/Div:		
Care Card Number:		Date of Plan:		
CONTACT INFORMATION				
Parent/Guardian 1:	Name:			<input type="checkbox"/> Call First
Phone Numbers:	Cell	Work	Home	Other
Parent/Guardian 2:	Name:			<input type="checkbox"/> Call First
Phone Numbers:	Cell:	Work:	Home:	Other:
Other/Emergency:	Name:		Relationship:	
	Able to advise on diabetes care: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Phone Numbers:	Cell:	Work:	Home:	Other:
Have emergency supplies been provided in the event of a natural disaster? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, location of emergency supply of insulin: _____				
STUDENTS RECEIVING NSS DELEGATED CARE				
NSS Coordinator: _____ Phone: _____				
School staff providing delegated care:				

Parent Signature: _____ Name: _____

Date: _____

Provincial Standards: Supporting Students with Type 1 Diabetes in the School Setting

**MEDICAL ALERT - TREATING MILD TO MODERATE LOW BLOOD GLUCOSE NOTE: PROMPT ATTENTION
CAN PREVENT SEVERE LOW BLOOD GLUCOSE**

SYMPTOMS	TREATMENT FOR STUDENTS NEEDING ASSISTANCE (<u>anyone</u> can give sugar to a student):		
<input type="checkbox"/> Shaky, sweaty <input type="checkbox"/> Hungry <input type="checkbox"/> Pale <input type="checkbox"/> Dizzy <input type="checkbox"/> Irritable <input type="checkbox"/> Tired/sleepy <input type="checkbox"/> Blurry vision <input type="checkbox"/> Confused <input type="checkbox"/> Poor coordination <input type="checkbox"/> Difficulty speaking <input type="checkbox"/> Headache <input type="checkbox"/> Difficulty concentrating Other:	<p>Location of fast acting sugar: _____</p> <p>1. If student able to swallow, give one of the following fast acting sugars:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> 10 grams <input type="checkbox"/> ___ glucose tablets <input type="checkbox"/> 1/2 cup of juice or regular soft drink <input type="checkbox"/> 2 teaspoons of honey <input type="checkbox"/> 10 skittles <input type="checkbox"/> 10 mL (2 teaspoons) or 2 packets of table sugar dissolved in water <input type="checkbox"/> Other (ONLY if 10 grams are labelled on package): </td> <td style="width: 50%; vertical-align: top;"> OR 15 grams <input type="checkbox"/> ___ glucose tablets <input type="checkbox"/> 3/4 cup of juice or regular soft drink <input type="checkbox"/> 1 tablespoon of honey <input type="checkbox"/> 15 skittles <input type="checkbox"/> 15 mL (1 tablespoon) or 3 packets of table sugar dissolved in water <input type="checkbox"/> Other (ONLY if 15 grams are labelled on package): </td> </tr> </table> <p>2. Contact designated emergency school staff person. 3. Blood glucose should be re-checked in 15 minutes. 4. Re-treat (as above) and call parent to notify if symptoms do not improve and/or blood glucose remains below 4 mmol/L. 5. Do not leave student unattended until blood glucose 4 mmol/L or above. 6. Give an extra snack such as cheese and crackers if next planned meal/snack is not for 45 minutes.</p>	10 grams <input type="checkbox"/> ___ glucose tablets <input type="checkbox"/> 1/2 cup of juice or regular soft drink <input type="checkbox"/> 2 teaspoons of honey <input type="checkbox"/> 10 skittles <input type="checkbox"/> 10 mL (2 teaspoons) or 2 packets of table sugar dissolved in water <input type="checkbox"/> Other (ONLY if 10 grams are labelled on package):	OR 15 grams <input type="checkbox"/> ___ glucose tablets <input type="checkbox"/> 3/4 cup of juice or regular soft drink <input type="checkbox"/> 1 tablespoon of honey <input type="checkbox"/> 15 skittles <input type="checkbox"/> 15 mL (1 tablespoon) or 3 packets of table sugar dissolved in water <input type="checkbox"/> Other (ONLY if 15 grams are labelled on package):
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MEDICAL ALERT – GIVING GLUCAGON FOR SEVERE LOW BLOOD GLUCOSE

SYMPTOMS	PLAN OF ACTION
<ul style="list-style-type: none"> • Unconsciousness • Having a seizure (or jerky movements) • So uncooperative that you cannot give juice or sugar by mouth and unable to swallow 	<ul style="list-style-type: none"> • 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



MEDICATION INSTRUCTIONS– Glucagon (Intramuscular or Intranasal)

Intranasal (Baqsimi)	Intramuscular (GlucaGen or Lilly Glucagon)
Dose & Route	Dose & Route
<input type="checkbox"/> Baqsimi® 3 mg nasal powder given in one nostril (for students 4 years and above)	<input type="checkbox"/> 0.5 mg = 0.5 ml by intramuscular injection (for students 5 years of age and under) <input type="checkbox"/> 1.0 mg = 1.0 ml by intramuscular injection (for students 6 years of age and over)
Directions as Ordered (see below)	Directions as Ordered (see below)
<ul style="list-style-type: none"> • Remove shrink wrap on tube by pulling the red stripe • Open the lid and remove the device from tube • Hold the device between 2nd and 3rd fingers and thumb (do not push yet!) • Insert device tip gently into one nostril until your fingers touch outside of student's nose • Push the plunger firmly all the way in until the green line is no longer showing • Throw away device/tube; single use only • Once student is alert, give juice or alternate fast-acting sugar 	<ul style="list-style-type: none"> • 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

Diabetes Medication Administration Form

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)
- 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: _____

Injectable Glucagon (GlucaGen® or Lilly Glucagon™)	Intranasal Glucagon (Baqsimi®)
For severe low blood glucose, give 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	For severe low blood glucose, give by intranasal route: Baqsimi® 3 mg (if available)
Insulin (rapid acting insulin only)	
Insulin delivery device: insulin pump insulin pen (Junior 1/2 unit pen only) Note: The following cannot be accommodated when insulin administration is being delegated to a school staff person via pump or pen: <ul style="list-style-type: none"> • 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 Bolus-calculating meter (e.g. Libre, Insulinx Meter / Insulin Mentor Meter) Fixed Amount/Dose: _____ units (include insulin name and amount)	
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).	
I agree the student's diabetes can be safely managed at school within the above parameters.	

Physician Signature: _____ Date: _____

Physician Name: _____ Clinic Phone Number: _____

Reference:

Fillable document created from Ministries of Health, Education and Child Care, and Children and Family Development (March, 2015; page 16).
Provincial Standards: Supporting Students with Type 1 Diabetes in the School Setting (pg. 16). Vancouver, BC: Author.