PEN #

BOARD OF EDUCATION BURNABY SCHOOL DISTRICT 41

DIABETES ACTION PLAN (FORM 1B)

STUDENT INFORMATION ☐ **Wears Medic Alert ID**

Student Name | BD year/month/day | Parent/Guardian Name

Parent/Guardian Home Phone # | Parent/Guardian Business Phone #

Emergency Contact Name/Phone # | Physician Name/Phone #

My child's information is:

Diagnosed with diabetes (year) _____

☐ Needs supervision for: ☐ a.m. snack ☐ lunch ☐ p.m. snack ☐ blood sugar monitoring

☐ Recognizes symptoms and is capable of treating low blood sugar

My child's symptoms at time of LOW blood sugar reaction are usually:

☐ trembling ☐ headache ☐ irritability ☐ fatigue ☐ pallor ☐ cold, clammy skin ☐ sweating ☐ nausea

☐ behaviour change ☐ excessive hunger ☐ blurred vision ☐ dizziness ☐ shakiness, lack of co-ordination

☐ staggering gait ☐ other symptoms may occur and indicate low blood sugar _____

MY CHILD'S TREATMENT FOR LOW BLOOD SUGAR SYMPTOMS IS:

1. **Give Sugar Immediately:** Location of sugar treatment ☐ on student ☐ other
   School Location_____
2. **Wait 10-15 minutes. If there is no improvement, repeat the above treatment.**
3. **If condition improves in 10-15 minutes, give a protein/carbohydrate snack such as cheese and crackers if next meal is more than one hour away. Observe child for a minimum of 30 minutes.**
4. **Call Parent or Emergency contact if blood sugar level remains below 4 after two treatments or if low blood sugar symptoms continue to exist.**

If student is unconscious, having a seizure or unable to swallow, <u>DO NOT</u> give food or drink.. call 911

- **roll student on his/her side and protect from injury**
- **inform parent or guardian**

<u>DO NOT LEAVE THE STUDENT ALONE</u>

This form must be kept in the School Health Resource Binder (red binder) "Medical Alert Section"

DIABETES ACTION PLAN For:

_____

Student Name

HIGH BLOOD SUGAR

My child's symptoms at time of HIGH blood sugar reaction are usually:

☐ headache ☐ drowsiness ☐ behaviour change ☐ frequent urge to urinate ☐ nausea/stomach pain
☐ excessive thirst ☐ dry mouth ☐ other: _____

Treatment for HIGH blood sugar is: _____

- **If blood sugar is over _____ notify parent.**
- **The school is not responsible for administering insulin.**

Parent/Guardian Authorization

The parent/guardian of the above named student must check the following information and sign this plan.

☐ I authorize the staff of the Burnaby School District and its agents to administer the designated treatment and to obtain suitable medical assistance.
☐ I have provided emergency sugars and snacks for the treatment of low blood sugar.
☐ I have provided a glucometer and adequate supplies for the monitoring of blood sugar levels for my child.
☐ My child is aware of safe disposal of sharps and supplies.
☐ If changes occur to my child's condition I will contact the school and provide revised information.

Your child's personal information is collected under the authority of the *School Act* and the *Freedom of Information and Protection Act.* The Board of Education may use your child's personal information for the purposes of:

- Health, safety, treatment and protection
- Emergency care and response

If you have any questions about the collection of your child's personal information, please contact the school principal directly. By signing this form, you give your consent to the Board of Education to disclose your child's personal information to the school staff and persons reasonably expected to have supervisory responsibility of school-aged students and preschool age children participating in early learning programs for the above purposes. This consent is valid and in effect until it is revoked in writing by you.

Parent/Guardian Signature: _____ Date Completed: _____

This agreement must be reviewed at the beginning of every school year and when changes occur.

Dates Reviewed by Parent/Guardian _____ _____ _____

Copies to: _____Parent(s) _____School Health Resource Binder (red binder)
_____Nursing Support Care Plan (if necessary) _____Student's Emergency Kit