SCHOOL DISTRICT No. 36 (Surrey)

# MEDICAL ALERT INFORMATION AND CARE PLAN (Diabetes)

Student Name:________________________________________

Birthdate:____________________ Personal Health Number:____________________

Date Information Provided:________________________________

Date when this information was reviewed by Parent/Guardian (minimum annually):

| ________________ | ________________ | ________________ |
|---|---|---|
| (date of review) | (date of review) | (date of review) |
| ________________ | ________________ | ________________ |
| (date of review) | (date of review) | (date of review) |

**School emergency contact information:**

| | **Name** | **Phone Number** |
|---|---|---|
| Family Doctor | | |
| Mother | | |
| Father | | |
| Alternate Contact | | |
| Alternate Contact | | |
| Alternate Contact | | |

*Medical Condition (Physician diagnosed):*______________________________

**Specific Symptoms to watch for:**

1. ________________________________________
2. ________________________________________
3. ________________________________________
4. ________________________________________
5. ________________________________________

## Procedures to deal with a problem: – DIABETES –

The only problem a student with diabetes is likely to have in school will be an insulin reaction (too little sugar in the blood). These should not occur frequently. They are usually brought on by more exercise than usual, delay in having a meal or a smaller meal than usual.

SYMPTOMS OF INSULIN REATION MAY BE: Hunger – Trembling – Drowsiness – Perspiring – Weakness – Abnormal Behaviour – Tingling of Mouth and Fingers

TREATMENT: Give sugar immediately (sugar, candy, sweetened fruit juice). Keep the student under observation until he/she returns to normal – usually 10-15 minutes. He/she should not be sent home, but parent or guardian should be notified of all suspected insulin reactions. Call 911 if the student is unable to swallow sugar or loses consciousness.

**Additional Comments:** ______________________________

______________________________

**Medication needed:** YES □ NO □ Location at the School: ______________

**Medication is Self Administered:** YES □ NO □

Name of Medication:______________________ Expiry Date: __________

Details (Specific side effects, storage, etc):

______________________________

______________________________

______________________________

**Training Documentation:**

| Name of School | Date of Training/Review | Trainer |
|---|---|---|
| | | |
| | | |
| | | |

- I am aware of Board Policy and Regulation on the Treatment of Students with Medical Problems.
- I agree that the above information is correct.
- If changes occur I will contact the school and provide revised instructions.
- I agree that if medication is required I will supply it to the school in the original container with my child's name and the pharmacist's directions for use, including dosage.
- I am aware that no medication will be administered until this form is completed and returned.
- I am aware that the Public Health Nurse for the school will be informed of my child's condition and medication and that the nurse may contact me as necessary.
- I am aware that staff working with my child may need to know of my child's condition and of the medication required.
- I am aware I am required to update this information each September.

______________________ ______________________________

(Date) (Signature of Parent/Guardian)