PRAIRIE SPIRIT SCHOOL DIVISION

Diabetes School Support Plan

(All sections must be completed.)

SCHOOL YEAR: _____

Place Student's Photo Here

Student's Name:	Date of Birth:	
Parent/Guardian:	Phone:	Other Phone:
Other Emergency Contact:	Phone:	Other Phone:
Primary Diabetes Physician:	Phone:	
Significant Medical History:		

Daily Schedule of Required Tasks*

Time	BG check	Meal/Snack	Insulin	Comments

If applicable, insulin dosing schedule to be provided separately

Legend: A – assistance required S – with supervision I – independent N/A – not applicable BG – blood glucose/sugar

Emergency Kit Location(s): _____

Emergency Kit should include: _____

Low Blood Sugar (mild hypoglycemia): Check, Treat, Repeat

If BG is under 4 mmol/L: Treat, then repeat BG check after 10-15 minutes
Treat again if still under 4 mmol/L
Treat and repeat this cycle until the BG is 4 or more

Treat with:
- ☐ _____ glucose tablets
- ☐ _____ cup juice/regular pop
- ☐ _____ Skittles
- ☐ Other _____

Usual symptoms of low blood sugar for student are:
- ☐ shaky ☐ blurred vision
- ☐ sweating ☐ weak/fatigue
- ☐ hungry ☐ dizzy
- ☐ confused ☐ headache
- ☐ pale
- ☐ other _____

High Blood Sugar (hyperglycemia): Not usually emergency

Call parent/guardian if BG is above _____ mmol/L or if student is unwell.
☐ Check ketones if BG is above _____. Contact parent.

Other instructions: _____

NOTE: *For future changes to diabetes required tasks, parent/guardian is authorized to provide directions to school without physician signature.*

Physician Signature: _____ Date: _____ ☐ on file

Parent/Guardian Signature: _____ Date: _____

Principal's Initials