

SCHOOL DISTRICT No. 36 (Surrey)

MEDICAL ALERT INFORMATION AND CARE PLAN (Diabetes)

Birthdate:	Personal Hea	Personal Health Number:	
Date Information Provided:			
Date when this information wa	s reviewed by Parent/Guardian (minii	mum annually):	
(date of review)	(date of review)	(date of review)	
(date of review)	(date of review)	(date of review)	
(date of review)	(acto el lettett)	()	
· · · · ·	х, , , , , , , , , , , , , , , , , , ,	(,	
School Emergency Contact	х, , , , , , , , , , , , , , , , , , ,	Phone Number	
· · · · ·	Information:	, , , , , , , , , , , , , , , , , , ,	
School Emergency Contact	Information:	, , , , , , , , , , , , , , , , , , ,	
School Emergency Contact	Information:	, , , , , , , , , , , , , , , , , , ,	
School Emergency Contact	Information: Name	, , , , , , , , , , , , , , , , , , ,	
School Emergency Contact	Information:	, , , , , , , , , , , , , , , , , , ,	
School Emergency Contact	Information: Name	, , , , , , , , , , , , , , , , , , ,	

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 REACTION 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: _____

Training Documentation: Name of School		Date of Tra	aining/Review	Trainer
Details (Specific	side effects, s	torage, etc	.):	
Name of Medicat	tion:			Expiry Date:
Medication is Self-Adr	ninistered:	□ Yes	□ No	
Medication needed:		□ No	Location at the So	chool:

- I am aware of Board Policy and Regulation of 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 direction 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 my 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.