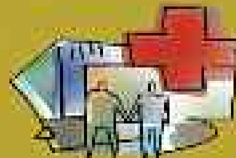
School intervention protocol for students with Type 1 diabetes

Forms to be completed by parents



Santé
et Services sociaux
Québec

DESIGN, DEVELOPMENT AND WRITING

Nathalie Dubé, clinical counsellor-nursing, Centre de santé et de services sociaux (CSSS) de la Vieille-Capitale

Nicole Lachance, consultant for the ministère de l'Éducation, du Loisir et du Sport (MELS)

Lyse Lapointe, coordinator of the motor and organic impairments file at the ministère de l'Éducation, du Loisir et du Sport (MELS)

Jacques Pelletier, school nurse, CSSS de la Vieille-Capitale

Laurence Rivet, physical health advisor, Ministère de la Santé et des Services sociaux (MSSS)

The forms in this document were taken from the:
Protocole d'intervention en milieu scolaire pour les élèves atteint de diabète de type 1
(11-215-01)

Produced by:
Direction des communications, ministère de la Santé et des Services sociaux

This document is available online and can be ordered at **www.msss.gouv.qc.ca** by clicking **Documentation** and then **Publications**.

It may also be ordered at diffusion@msss.gouv.qc.ca or by mail at:
Ministère de la Santé et des Services sociaux
Direction des communications Diffusion
1075, chemin Sainte-Foy,
4e étageQuébec
(Québec)G1S 2M1

Masculine pronouns are used generically in this document.

Legal deposit
Bibliothèque et Archives nationales du Québec, 2012
Library and Archives Canada, 2012
ISBN : 978-2-550-66306-5 (print version)
ISBN : 978-2-550-66273-0 (PDF)

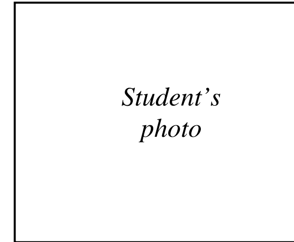
All rights reserved for all countries. Any reproduction whatsoever, translation or dissemination, in whole or in part, is prohibited unless authorized by Les Publications du Québec. However, reproduction or use for non-commercial personal, private study or scientific research purposes
is permitted, provided the source is mentioned.

© Gouvernement du Québec, 2012

To be completed by the parents and the school nurse

To be kept in file: - Special student assistance
- CLSC

IDENTIFICATION OF DIABETIC STUDENT



Family name and given name: ____________________________

Level and class: ____

Name of teacher: ______________________________________

Contact information for persons to be informed:

	Parents		**Other persons**	
	Mother	Father		
Family and given name				
Cell phone				
Work phone				
Home phone				
Pager				

Contact information for healthcare providers:

	Name	**Phone**
Attending physician		
Nurse at the diabetes clinic		

CONSENT	**YES**	**NO**
I consent to the nurse providing the information in this document to school staff who may intervene in the event of an emergency.		
I authorize the school staff to administer the prescribed treatment for hypoglycemia according to the decision tree that appears in the intervention guide.		

Signature of person having parental authority: ______________________________

Date _______/_______/_______

Signature of nurse: ____

Date _______/_______/_______

To be completed by the parents

To be kept in file: - Special student assistance
- CLSC

AUTHORIZATION AND CONSENT TO THE INTERVENTION PROTOCOL

Student: ______________________________ ________________________________
Family name Given name

Date of birth: ________/_________/________
Day Month Year

Class: ________________________ ____
Level Name of teacher

Name of parent: _____________________________ _______________________________
Family name Given name

I have read the above-mentioned intervention protocol.

Yes ☐ No ☐

I authorize and agree to the terms and conditions of the intervention protocol concerning my child's diabetes.

Yes ☐ No ☐

____ ___________________________
Signature of person having parental authority **Date**

This signature is valid until it is revoked in writing by one of the parties.

Return the signed form to the nurse.

To be completed by the school nurse

To be kept in file: - CLSC

DATA COLLECTION[1]

Student's name: ____________________ Date of birth: ______/______/______

Class: ____________________________ School: __________________________

PHYSICAL STATE OF HEALTH

Type 1 diabetes Since: ________________

Diabetes clinic: ________________________________

Physician: ____________________________________

Nurse: _______________________________________

Medication: __________________________Number of times per day: __________

Compliance with treatment: ☐ Yes ☐ No

Self-medication: ☐ Yes ☐ No ☐ Partial

Particularities: ____

____

☐ Allergies______________________ ☐ Intolerance______________________

☐ Disability_____________________ ☐ Deficit: ________________________

Psychomotor development: Language _________________________________

Fine motor skills ____________________________

Gross motor skills ___________________________

Particularities: ____

____

1. P. BIROT, M.-P. DERVAUX and M. PEGON, (2005), "Le modèle de McGill", *Recherche en soins infirmiers*, No. 80, pp. 28-38.

LIFE HABITS

Nutrition: ☐ For diabetics ☐ Balanced ☐ Deficient

Activities and recreation: ______________________________

Particularities: ______________________________

PSYCHOLOGICAL STATE OF HEALTH

Emotional state

Reported by family	At school	At the appointment

Type of behaviour

Reported by family	At school	At the appointment

Socialization
with peers: ______________________________

with adults: ______________________________

LEARNING – DEVELOPMENT (goals, desires)

____
____
____

Particularities: ______________________________
____

To be kept in file: - CLSC

ENVIRONMENT

Type of dwelling: ______________________________________

Environment: ☐ urban ☐ semi-rural ☐ rural

Lives with:____

Type of family: ☐ traditional ☐ single-parent
☐ blended _________________________
☐ other____________________________

Ethnic group: _______________ Religion:_______________

Language spoken in the home: ____________________________

Quality of
communication:____

Stressful events in the family:____

____

Meaningful
persons:____

Support received by the family: ☐ Yes ☐ No _________________________

Family's attitude toward diabetes management at
school:____
____

Family's financial situation: ____
Particularities: ____
____
____

________________________________ ________________________
Signature of nurse Date

To be kept in file: - Special student assistance
- CLSC

To be completed by the parents

IDENTIFICATION OF CAREGIVER*

I authorize (name of caregiver) ______________________________to intervene with my diabetic child at school or the school daycare.

Signature of person having parental authority: __________________________________

Date: __________/____________/_____________

If necessary, I agree to intervene with: (name of child)

____

Signature of caregiver: ______________________

Date: __________/____________/_____________

Practical application of the *Act to amend the Professional Code and other legislative provisions in the field of health* (Bill 90).

CONTACT INFORMATION FOR THE CAREGIVER

FAMILY NAME, GIVEN NAME: ____

ADDRESS: ____

PHONE: ____

CELL: ____

PAGER: ____

* A caregiver is a family member or friend who provides regular care and support to another person, without pay. He or she is a person from the entourage who provides significant, ongoing or occasional non-professional support to someone with a disability.

Ref.: ASSOCIATION DES CLSC ET DES CHSLD DU QUÉBEC, *Application pratique de la Loi modifiant le Code des professions et d'autres dispositions législatives dans le domaine de la santé* (Bill 90), 2003.

To be completed by the school nurse

To be kept in file: - CLSC

LIST OF ITEMS OR PRODUCTS FOR EMERGENCY KITS

Family name and given name: ____________________________ Class: ____________________________

STUDENT MULTIPLE INJECTIONS OR INSULIN PUMP		CLASSROOM AND ELSEWHERE MULTIPLE INJECTIONS OR INSULIN PUMP	
☐	Student identification sheet	☐	Student identification sheet
☐	Juice boxes (3)	☐	Juice boxes (3)
☐	Glucose bar (Dextrosol, Dex 4)	☐	Glucose bar (Dextrosol, Dex 4)
☐	Blood glucose monitor	Other items/products: ____________________________________ ____	
☐	Lancets		
☐	Strips		
Other items /products: ______________________________ ____ ____			

MAIN KIT
(LOCATION ACCESSIBLE AT ALL TIMES)

MULTIPLE INJECTIONS		INSULIN PUMP
☐	Student identification sheet for diabetic student	☐
☐	Instructions for intervention in the event of hypoglycemia or hyperglycemia	☐
☐	Juice (3 boxes)	☐
☐	Glucagon, including instructions	☐
☐	Glucose bar (Dextrosol, Dex. 4)	☐
☐	Quick glucose (Insta-Glucose, maple syrup, honey)	☐
☐	Lancets	☐
☐	Strips	☐
☐	Calibrated blood glucose monitor (with spare batteries)	☐
	Instructions for pump	☐
	Spare batteries (for insulin pump)	☐
	To change batteries: a quarter (25¢), to open battery cover on insulin pump	☐

OPTIONAL ITEMS AND PRODUCTS

Calibrated blood glucose monitor to measure ketones (several strips to measure the ketones)	Insulin reservoir for pump
Tuberculin syringe	Infusion set (catheter included)
Emla cream or patches	1 bottle of insulin, kept in fridge
Bottle of hand sanitizer	Tissues
Plastic adhesive bandages (6 cm x 7 cm, 4 cm x 4 cm)	Alcohol swabs
Sterile dressing	Pen
Other items/products: ____ ____	

Signature of person having parental authority: ____ Date:________________

Signature of nurse:____ Date:________________

To be completed by the school administration

To be kept in file: - School

INFORMATION TO BE PROVIDED TO SCHOOL TRANSPORTATION SERVICE

A. To be completed at end of school year in order to plan the coming year

Name of school		For use by transportation service
Names of students	Address (Number, street, municipality)	Route No.

B. If a new student arrives during the school year

Name of school: ______________________________

Student's name: ______________________________

Student's address: ______________________________
Number Street

____
Municipality

For use by transportation service:

Route No.: ____________________

www.msss.gouv.qc.ca

Santé
et Services sociaux
Québec

12-215-01WFA