This plan should be completed by the student's personal health care team, including the parents/guardian. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse and other authorized personnel.

Date of Plan: **This plan is valid for the current school year:**

STUDENT INFORMATION

Student's Name:

Date of Birth:

Medical Diagnosis: Glucose Transporter Type 1 Deficiency Syndrome

Medical Treatment: Ketogenic Diet 4:1 Ratio

School:

School Phone Number:

Grade:

Homeroom Teacher:

School Nurse:

Phone:

CONTACT INFORMATION

Parent/Guardian:
Address:
Telephone:
Email Address:

Student Physician/Health Care Provider:
Telephone:
Email Address:

Other Emergency Contacts:
Relationship:
Telephone:

Other Emergency Contacts:
Relationship:
Telephone:

KETOGENIC DIET

The ketogenic diet is a high fat, low carbohydrate diet provided as a treatment for children with student's diagnosis, glucose transporter type 1 deficiency syndrome (GLUT-1) as well as difficult-to-control seizures. Glucose transporter deficiency syndrome is a metabolic condition in which children cannot use sugar for energy; symptoms can include cognitive disability, movement abnormalities, low muscle tone, imbalance, and epilepsy.

Meal Accommodations: Meals should be consumed in full within 30 minutes and prompting may be required to assure that no additional time is needed. Student should be monitored, to prevent him from eating another child's food, and to prevent other children from eating his (the amounts he eats are precisely weighed).

Special event/party food permitted: Parents/guardian discretion

Student discretion

Instructions for when food is provided to the class (e.g., as part of a class party or food sampling event): Please inform parent of any events, so that arrangements can be made for student to participate.

Student's self-care nutrition skills:

Yes No Independently finishes entire meal.

Yes No May require supervision

Yes No Requires assistance with eating.

WATER REQUIREMENTS

The student shall be permitted to have immediate access to water by keeping a water bottle in the student's possession and at the student's desk, and by permitting the student to use the drinking fountain without restriction.

The student shall be permitted to use the bathroom without restriction.

Water Requirements: 25 ounce water bottle, 6 ounce lunch water.
Accommodations: Prompting may be required to assure all water is consumed.

PHYSICAL ACTIVITY AND SPORTS

The student shall be permitted to participate fully in physical education classes and team sports.

Physical education instructors and sports coaches must have a copy of the medical plan.

Water should be provided at least every 30 minutes during and after vigorous physical activity

FIELD TRIPS AND EXTRACURRICULAR ACTIVITIES

The student will be permitted to participate in all school-sponsored field trips and extracurricular activities (such as sports, clubs, and enrichment programs) with all of the accommodations and modifications, including necessary supervision by school personnel, set out in this Plan. The student's parent/guardian may be required to accompany the student on field trips.

TESTS AND CLASSWORK

If the student is affected by high or low ketones levels or any Glut1 Deficiency symptoms at the time of regular testing, the student will be permitted to take the test at another time without penalty.

If the student needs to take breaks to use the water fountain or bathroom, during a test or other activity, the student will be given extra time to finish the test or other activity without penalty.

The student shall be given instruction to help him/her make up any classroom instruction missed due to Glut1 Deficiency without penalty.

The student shall not be penalized for absences required for medical appointments and/or for illness. The parent will provide documentation from the treating health care professional if otherwise required by school policy.

COMMUNICATION

Encouragement is essential. The student should be treated in a way that encourages the student to eat snacks on time, and to progress toward self-care with his/her ketogenic diet management skills.

The teacher, school nurse or school personnel provide reasonable notice to parent/guardian when there will be a change in planned activities such as exercise, playground time, field trips, parties, or lunch schedule, so that the meal plan can be adjusted accordingly.

Each substitute teacher, substitute school nurse, and any other school or bus staff interacting with the student will be provided with written instructions regarding the student's Glut1 Deficiency care and a list of all school nurses.

EMERGENCY EVACUATION AND SHELTER-IN-PLACE

In the event of emergency evacuation or shelter-in-place situation, the student's Glut1 Deficiency Medical Plan will remain in full force and effect.

PARENT NOTIFICATION:

NOTIFY PARENTS/GUARDIANS IMMEDIATELY IN THE FOLLOWING SITUATIONS:

Symptoms such as continuous crying, extreme tiredness, seizure, or loss of consciousness.

Symptoms of excess ketosis, nausea, rapid breathing, flushing face, extreme tiredness.

The student refuses to eat or drink.

Any injury.

Other: _____

_____

_____

Call parent/guardian at numbers listed above. If unable to reach parent/guardian, call the other emergency contacts or student's health care providers.

SIGNATURES

This Ketogenic Diet Plan has been approved by:

Student's Physician/Health Care Provider Date

I, (parent/guardian:) _____ give permission to the school nurse or another qualified health care professional and personnel of (school:) _____ to perform and carry out the care tasks as outlined in (student:) _____ Ketogenic Diet Management Plan. I also consent to the release of the information contained in this Ketogenic Diet Management Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider.

Acknowledged and received by:

Student's Parent/Guardian Date

Student's Teacher Date

School Nurse Date

IEP Facilitator Date