LE GOUVERNEMENT
DU GRAND-DUCHÉ DE LUXEMBOURG
Ministère de la Santé
et de la Sécurité sociale

Direction de la santé

◯ Initial PAI
◯ Updated PAI

☐ Indefinite duration

Division de la Médecine Scolaire
et de la Santé des Enfants
et Adolescents

20, rue de Bitbourg
L - 1273 Luxembourg-Hamm
pai@ms.etat.lu
Tel. no. : 247-75540

PAI - Individualised Support Plan
DIABETES

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That information is kept by the administration in question for as long as it is required to achieve the purpose of the processing operation(s).
Your data will be shared with other public administrations that are necessary for the processing of your application. For details on which departments will have access to the data on this form, please contact the public administration you are filing your application with.
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1. Input

Fields marked with an * are mandatory

Identity of the applicant

Photo

ONLY for School Medical Service:

Child's/Student's family name(s):*

Child's/Student's first name(s):*

Nat. identification number(matricule):*
(or date of birth if no id number)

Cycle / class:

School/SEA:*

Place/Location:*

Name(s) of legal representative/parents:*

Address:*

Telephone:

Email address:

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Delegation of care

Fields marked with an * are mandatory

I,* _____

the undersigned, legal representative or adult student, request for my child or myself the implementing of an Individualised Support Plan (PAI) based on the medical prescription and emergency intervention protocol established by

Dr* _____

I authorise that this document be made known and applied by the people in charge of the student/child or myself : school, school health team, day care centre/SEA, SePAS.
It is my responsibility:

- to check the expiry date of medicines
- to replace them as soon as they reach the expiry date
- in the event of a change in the medical prescription, to inform the people responsible for the child/student and the school health team

Signature (mandatory)

Place:* _____

Date:* _____

Signature of legal representative or adult student:*

Prescribing physician

Name:* _____

Date:* _____

Signature:*

For the doctor at the National Health Directorate - Department for School Medicine and Health of Children and Young People

PAI received on: _____

forwarded to: _____

on: _____

Signature:

Child's/Student's family name(s): _____ Nat. identification number: _____

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2. Supervisory staff

School health team	Name	Job title	Tel. no.
Headteachers	Name	Job title	Tel. no.
Supervisory staff at day-care centre	Name	Job title	Tel. no.
SePAS/ESEB	Name	Job title	Tel. no.
Others	Name	Job title	Tel. no.

3. Doctors treating the child

Family doctor (GP)	Name	Address	Tel. no.
Specialists	Name	Address	Tel. no.

Child's/Student's family name(s): Nat. identification number:

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4. Transmission of the PAI / Concertation meeting

Information session:

Date:

Attendance list - People who have knowledge of the PAI

(give names and job titles of all people who have knowledge of the PAI)

Job title	Family name/First name	Signature	Date
Head teacher			
Educator			
Person in charge of the day-care centre			
Staff at day-care centre			
SEPAS			
ESEB			
Others			
Others			
Others			

For the School Health Team

A copy of the PAI has been handed to:

Date:

IMPORTANT: Instructions for staff responsible for the child/student:

- **Please inform the school principals in basic/secondary education establishments, the teachers, the supervisory staff and the supply teachers of the existence of this document.**
- **Send a copy of this page to *Division de la Médecine scolaire* (by post to: 20 Rue de Bitbourg, L-1273 Luxembourg-Hamm) after the people concerned have read the PAI and their signatures have been obtained.**

Child's/Student's family name(s): Nat. identification number:

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5. TREATMENT DURING SCHOOL TIME

The pupil must always have the following at hand:

No.	Glucose administration foods:	No.	Necessary equipment:
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	
6.		6.	

The family commits to providing the specified equipment and a sufficient quantity of glucose administration foods.

6. THE CHILD'S/STUDENT'S SPECIFIC NEEDS

In class:
The child/student must have the possibility of checking his/her blood sugar level, eating, drinking or going to the toilet if he/she starts feeling unwell. Do not ask him to wait until breaktime. Young children need the assistance of an adult to perform the tests and to administer insulin.

Checking blood sugar level in class or elsewhere / day-care centre: ◯ Yes ◯ No

Blood sugar level checked by:

When:

Where:

Treatment on school premises:

The child/student needs to be given insulin while he/she is at school: ◯ Yes ◯ No

Administration method: ◯ pump ◯ injections

If yes, **who** administers insulin or bolus if a pump is used:

At what **time**: **Where**:

Person deciding the dose:

*protocol validated by DECCP

Blood sugar level higher than:

Child's/Student's family name(s): Nat. identification number:

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Other treatment:

Meals:

Light meals and/or snacks (times):

Person responsible for the carbohydrate count and method used:

	CLINICAL SIGNS TO WATCH OUT FOR	WHAT TO DO
	MINOR SIGNS: **The ticked symptoms are predominant in this child**	
☐	The child/adolescent says `I'm hungry' or `I'm having a hypo'	1. Test his/her blood sugar level
☐	Dizziness	2. If the value is less than mg/dl:
☐	Fatigue	
☐	Blurred vision (eyes look very bright)	**=> RAISING BLOOD SUGAR:**
☐	Pale skin	
☐	Sweating	3. Check level again after 30 minutes, if still less than mg/dl:
☐	Difficulty speaking	
☐	Abrupt change in mood - aggressive, as if inebriated, listless, fidgety	**=> give more sugar**
☐	Shaking	
☐	Headache	
	MAJOR SIGNS:	
	Faintness such that it is **impossible** to give the child sugar by mouth Loss of consciousness/convulsions	- inject glucagon IM or administer the baqsimi intranasally - call **112**

Always stay with the child or adolescent; call the family or the mobile number:

*protocol validated by DECCP

Child's/Student's family name(s): Nat. identification number:

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7. Instructions

1. Emergency kit

PLACE A COPY OF THIS DOCUMENT IN THE EMERGENCY KIT

Content / Medicines	
Location	
School	☐
Day-care centre/SEA	☐
Other	☐

- **IF THE SAMU EMERGENCY SERVICE IS CALLED, INFORM THEM OF THE EXISTENCE OF THIS DOCUMENT**
- **INFORM THE PARENTS**
- **THE EMERGENCY KIT MUST FOLLOW THE CHILD ON ALL JOURNEYS OUTSIDE THE SCHOOL**

2. Accomodations (physical activities, swimming, excursions, etc):

3. Any other arrangements:

Signature

Place:*

Date:*

Stamp of the doctor:*

Child's/Student's family name(s):

Nat. identification number: