FORM 6 - DIABETES MANAGEMENT & EMERGENCY RESPONSE PLAN

Name:	Date of Birth	Year:	Form:	Teacher:

1. Health Condition - Diabetes Type 1 ☐ **Diabetes Type 2** ☐ **(Please Tick)**

2. Medication	**Oral**	☐
2.1 Form Of Administration	**Injection**	☐
	Pump	☐

2.2. Complete if your child requires ***oral*** diabetes medication.

Name of Medication	Dose	Timing

Is your child able to self-administer their medication? Yes ☐ **No** ☐ **If no, see page 3**

Storage instructions: Refrigerate ☐ **Keep out of sunlight** ☐ **Other** _____

2.3 Complete if, your child requires ***insulin injections*** for diabetes.

Name of Medication	Dose	Timing

Is your child able to self administer their medication? Yes ☐ **No** ☐

Medication storage instructions: Refrigerate ☐ **Keep out of sunlight** ☐ **other** _____

2.4 Complete if, your child needs an ***insulin pump*** for diabetes medication.

Type of Pump:

Insulin/Carbohydrate Ratio	**Correction Factor**
Insulin/Carbohydrate Ratio	**Correction Factor**
Insulin/Carbohydrate Ratio	**Correction Factor**

Parent/Carer authorisation should be sought before administering a correction dose for high glucose levels.

2.5 Please tick to indicate your child's abilities in managing their insulin pump.

	Needs Assistance	
Counts carbohydrates	YES ☐	NO ☐
Bolus correct amount for carbohydrates consumed	YES ☐	NO ☐
Calculates and administers corrective bolus	YES ☐	NO ☐
Calculates and sets basal profiles	YES ☐	NO ☐
Calculates and sets temporary basal rate	YES ☐	NO ☐
Disconnects pump and reconnects pump	YES ☐	NO ☐
Prepares reservoir and tubing	YES ☐	NO ☐
Inserts infusion set	YES ☐	NO ☐
Troubleshoots alarms and malfunctions	YES ☐	NO ☐

3. Food Management at School

It is expected that parents/carers will provide regular meals/snacks for their child. However, if your child requires additional snacks, e.g. before, during or after physical activity, please complete the table below.

Time of Day Required	Food Type	Amount	Is supervision required?

3.1 Foods to avoid, if any

Instructions for when food is provided to the class (e.g. as part of a class party or food sampling)

Name: **DOB:** **Year:** **Form:** **Teacher:**

4. Exercise Restrictions

Restrictions on activity, if any:

My child **should not** exercise if his or her **blood glucose level is below** _____ mmol/l **or** _____ **above** _____ mmol/l **or if ketones are** _____

5. Hypoglycemia (Low Blood Sugar)

Usual symptoms:

Treatment for a mild to moderate reaction:

Treatment for a severe reaction:
If the child is unconscious or non-responsive, first aid principles apply.

- **Do not put anything into the child's mouth.**
- **Call an ambulance**
- **Call parents/carers as soon as possible**

6. Hyperglycemia (High Blood Sugar)

Usual symptoms:

Treatment for a mild to moderate reaction:

Treatment for a severe reaction: (treatment will vary for individual children)

7. Ketones

Treatment for ketones levels: Contact parents and request them to collect the student for medical management.

8. Emergency items to be left at school

Glucose tablets					
Snack	YES	☐	**NO**	☐	
Syringes	YES	☐	**NO**	☐	
Blood glucose meter	YES	☐	**NO**	☐	
Insulin	YES	☐	**NO**	☐	
Ketone strips	YES	☐	**NO**	☐	
Other (Please list)	YES	☐	**NO**	☐	
	YES	☐	**NO**	☐	

9. Authority to Act

This diabetes management and emergency response plan authorises school staff to follow my/our advice and/or that of our medical practitioner. It is valid for one year or until I/we advise the school of a change in my/our child's health care requirements.

Parent/Carer Signature:	**Medical practitioner's signature: (if required)**
Date:	**Date:**
Review Date:	

OFFICE USE ONLY

Date received:	Date uploaded on SIS:
Is specific staff training required? **Yes** ☐ **No** ☐:	Type of training
Training service provider:	
Name of person/s to be trained:	Date of training:

When completed, please attach to the *Student Health Care Summary*.