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

2.1 Form Of Administration

☐ Oral
☐ Injection
☐ Pump

Note: All medication must be provided by parents/carers

2.2. Complete if your child requires oral diabetes medication.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dose</th>
<th>Timing</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dose</th>
<th>Timing</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Needs Assistance</th>
<th>Counts carbohydrates</th>
<th>Bolus correct amount for carbohydrates consumed</th>
<th>Calculates and administers corrective bolus</th>
<th>Calculates and sets basal profiles</th>
<th>Calculates and sets temporary basal rate</th>
<th>Disconnects pump and reconnects pump</th>
<th>Prepares reservoir and tubing</th>
<th>Inserts infusion set</th>
<th>Troubleshoots alarms and malfunctions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES ☐ NO ☐</td>
<td>YES ☐ NO ☐</td>
<td>YES ☐ NO ☐</td>
<td>YES ☐ NO ☐</td>
<td>YES ☐ NO ☐</td>
<td>YES ☐ NO ☐</td>
<td>YES ☐ NO ☐</td>
<td>YES ☐ NO ☐</td>
<td>YES ☐ NO ☐</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Time of Day Required</th>
<th>Food Type</th>
<th>Amount</th>
<th>Is supervision required?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)
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

<table>
<thead>
<tr>
<th>Item</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucose tablets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Snack</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syringes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood glucose meter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insulin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ketone strips</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Please list)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: ____________________________

Date: ____________________________

Medical practitioner's signature: (if required)

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.