

FORM 6 - DIABETES MANAGEMENT & EMERGENCY RESPONSE PLAN

Name: _____ Date of Birth: _____ Year: _____ Form: _____ Teacher: _____

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

2. Medication 2.1 Form Of Administration	Oral	<input type="checkbox"/>	
	Injection	<input type="checkbox"/>	
	Pump	<input type="checkbox"/>	

2.2. Complete if your child needs oral diabetes medication.

Name of Medication	Dose	Timing

Is your child able to self-administer their medication? Yes ☐ No ☐ If no, see page 3Storage instructions: Refrigerate ☐ Keep out of sunlight ☐ Other _____**2.3 Complete if, your child needs insulin injection 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 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 <input type="checkbox"/>	NO <input type="checkbox"/>
Bolus correct amount for carbohydrates consumed	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Calculates and administer corrective bolus	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Calculates and set basal profiles	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Calculates and set temporary basal rate	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Disconnects pump and reconnect pump	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Prepares reservoir and tubing	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Inserts infusion set	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Troubleshoots alarms and malfunctions	YES <input type="checkbox"/>	NO <input type="checkbox"/>

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	Food Type	Amount	Is Supervision Required?

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: _____ Date of Birth _____ 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	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Snack	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Syringes	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Blood glucose meter	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Insulin	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Ketone strips	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	
Other (Please list)	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	

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

Parent/Carer Signature: Date:	Medical Practitioner Signature: (if required)
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: _____

Complete and return to your child's school.

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