**FORM 6 - DIABETES MANAGEMENT & EMERGENCY RESPONSE PLAN**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth</th>
<th>Year:</th>
<th>Form:</th>
<th>Teacher:</th>
</tr>
</thead>
</table>

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

2. **Medication**
   - Oral
   - Injection
   - Pump

2.1 **Form Of Administration**

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.

<table>
<thead>
<tr>
<th>Type of Pump:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Insulin/Carbohydrate Ratio</th>
<th>Correction Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin/Carbohydrate Ratio</td>
<td>Correction Factor</td>
</tr>
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<td>Insulin/Carbohydrate Ratio</td>
<td>Correction Factor</td>
</tr>
</tbody>
</table>

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

Glucose tablets | YES | NO |
Snack | YES | NO |
Syringes | YES | NO |
Blood glucose meter | YES | NO |
Insulin | YES | NO |
Ketone strips | YES | NO |
Other (Please list) | 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: ____________________________
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.