FORM 6 - DIABETES MANAGEMENT & EMERGENCY RESPONSE PLAN

STUDENT DETAILS

SCHOOL:	YEAR: FORM:	INSERT PHOTO HERE
NAME:	DATE OF BIRTH:	
ADDRESS:	GENDER:	
FAMILY CONTACT DETAILS	TEACHER:	
NAME:	**MEDICAL DETAILS**	
ADDRESS:	DOCTOR(S):	
RELATIONSHIP TO STUDENT:	SPECIALIST:	TELEPHONE:
TELEPHONE: (W) (H) (M)	MEDICAL CENTRE:	
NAME:	PERMISSION IS GIVEN TO SEEK MEDICAL ATTENTION FOR MY CHILD AS REQUIRED FROM THE ABOVE MEDICAL CENTRE. YES ☐ NO ☐	
ADDRESS:	DO YOU HAVE AMBULANCE COVER? YES ☐ NO ☐ **IF THERE IS A MEDICAL EMERGENCY PARENTS/CARERS ARE EXPECTED TO MEET THE COST OF THE AMBULANCE.**	
RELATIONSHIP TO STUDENT:	**STUDENT HAS A MEDICALERT BRACELET/PENDANT** YES ☐ NO ☐ IF YES PROVIDE DETAILS:	
TELEPHONE: (W) (H) (M)		

HEALTH CARE PLANNING – TO BE COMPLETED BY PARENT/CARER/DOCTOR

1. HEALTH CONDITION: DIABETES: TYPE 1 ☐ TYPE 2 ☐ (Please tick)

2. MEDICATION

2.1 FORM OF ADMINISTRATION		
	ORAL	☐
	INJECTION	☐
	PUMP	☐

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 4
STORAGE INSTRUCTIONS: REFRIGERATE ☐ KEEP OUT OF SUNLIGHT ☐ OTHER _____

2.3 COMPLETE IF, YOUR CHILD NEEDS INSULIN INJECTION DIABETES MEDICATION

NAME OF MEDICATION	DOSE	TIMING

IS YOUR CHILD ABLE TO SELF ADMINISTER THEIR MEDICATION? YES ☐ NO ☐ IF NO SEE PAGE 4
STORAGE INSTRUCTIONS: REFRIGERATE ☐ KEEP OUT OF SUNLIGHT ☐ OTHER _____

PARENT/CARER SIGNATURE: _____ PRINCIPAL SIGNATURE: _____
DATE: / / FORM 6 PAGE 1 OF 5

NAME:	SCHOOL:	DOB:

2.4 COMPLETE IF YOUR CHILD HAS AN INSULIN PUMP

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			
COUNT CARBOHYDRATES	YES	☐	NO	☐
BOLUS CORRECT AMOUNT FOR CARBOHYDRATES CONSUMED	YES	☐	NO	☐
CALCULATE AND ADMINISTER CORRECTIVE BOLUS	YES	☐	NO	☐
CALCULATE AND SET BASAL PROFILES	YES	☐	NO	☐
CALCULATE AND SET TEMPORARY BASAL RATE	YES	☐	NO	☐
DISCONNECT PUMP AND RECONNECT PUMP	YES	☐	NO	☐
PREPARE RESERVOIR AND TUBING	YES	☐	NO	☐
INSERT INFUSION SET	YES	☐	NO	☐
TROUBLESHOOT 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	FOOD TYPE	AMOUNT	IS SUPERVISION REQUIRED?

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** _____.

PARENT/CARER SIGNATURE: _____ PRINCIPAL SIGNATURE: _____

DATE: / /

NAME: SCHOOL: DOB:

5. FOOD MANAGEMENT AT SCHOOL

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)

6. 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

7. HYPERGLYCEMIA (HIGH BLOOD SUGAR)

USUAL SYMPTOMS:

TREATMENT FOR A MILD TO MODERATE REACTION:

TREATMENT FOR A SEVERE REACTION: (TREATMENT WILL VARY FOR INDIVIDUAL CHILDREN)

8. KETONES

TREATMENT FOR KETONES LEVELS:
CONTACT PARENTS AND REQUEST THEM TO COLLECT THE STUDENT FOR MEDICAL MANAGEMENT.

PARENT/CARER SIGNATURE: _____ PRINCIPAL SIGNATURE: _____
DATE: / /

NAME: SCHOOL: DOB:

9. 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

10. STAFF TRAINING REQUIREMENTS

IS SPECIFIC TRAINING FOR STAFF REQUIRED TO SUPPORT YOUR CHILD? (YOU MAY LIKE TO DISCUSS WITH THE PRINCIPAL).

A. FOR DAILY MANAGEMENT? YES ☐ NO ☐ IF YES, PLEASE DESCRIBE:

B. IN AN EMERGENCY? YES ☐ NO ☐ IF YES, PLEASE DESCRIBE:

11. AGREEMENT BETWEEN THE SCHOOL PRINCIPAL, THE PARENT/CARER AND MEDICAL PRACTITIONER.

THE AGREEMENT AUTHORISES THE SCHOOL STAFF TO FOLLOW THE ADVICE OF THE STUDENT'S PARENT/CARER AND/OR MEDICAL PRACTITIONER AS SET IN THIS PLAN. IT IS VALID FOR ONE YEAR OR UNTIL I ADVISE THE SCHOOL OF A CHANGE IN MY CHILD'S HEALTH CARE REQUIREMENTS:

PRINCIPAL **DATE:**	**MEDICAL PRACTITIONER: (SIGNATURE REQUIRED)**
PARENT/CARER: **DATE:**	**REVIEW DATE:**

PARENT/CARER SIGNATURE: _____ PRINCIPAL SIGNATURE: _____

DATE: / /

NAME:	SCHOOL:	DOB:
OFFICE USE ONLY		
IS SPECIFIC STAFF TRAINING REQUIRED? **YES** ☐ **NO** ☐	DATE:	
TYPE OF TRAINING:		
NAME OF PERSONS TO BE TRAINED:		
PRINCIPAL SIGNATURE:		

COMPLETE AND ATTACH THE STUDENT HEALTH CARE SUMMARY FORM TO THE FRONT OF THIS DOCUMENT.