In response to your completion of Form 1, please complete this form to provide comprehensive detail of your child's health condition.

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	**Oral**	☐
2.1 Form Of Administration	**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 3**

Storage 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 ☐ NO ☐
Bolus correct amount for carbohydrates consumed	YES ☐ NO ☐
Calculates and administer corrective bolus	YES ☐ NO ☐
Calculates and set basal profiles	YES ☐ NO ☐
Calculates and set temporary basal rate	YES ☐ NO ☐
Disconnects pump and reconnect 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	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	☐	**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 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.