## 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>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</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>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</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>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counts carbohydrates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bolus correct amount for carbohydrates consumed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calculates and administers corrective bolus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calculates and sets basal profiles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calculates and sets temporary basal rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disconnects pump and reconnects pump</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepares reservoir and tubing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inserts infusion set</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Troubleshoots alarms and malfunctions</td>
<td></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>
<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>YES</td>
<td></td>
</tr>
<tr>
<td>Snack</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Syringes</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Blood glucose meter</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Insulin</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Ketone strips</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>Other (Please list)</td>
<td>YES</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: ____________________________
Medical practitioner’s signature: (if required) ____________________________
Date: ________________
Date: ________________

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: ____________________________
Medical practitioner’s signature: (if required) ____________________________
Date: ________________
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.