ARANMORE DIABETES MANAGEMENT & EMERGENCY RESPONSE PLAN

**NAME:**

**DATE OF BIRTH:**

**YEAR:**

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/caregivers

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 ☐

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 ☐

Storage instructions:  Refrigerate ☐ Keep out of sunlight ☐ Other

2.4 Complete if your child requires an INSULIN PUMP for diabetes

Type of pump:
- Insulin/Carbohydrate Ratio
- Insulin/Carbohydrate Ratio
- Insulin/Carbohydrate Ratio

Correction Factor
Correction Factor
Correction Factor

Parent/Caregiver authorisation should be sought before administering a correction dose for high glucose levels

2.5 Please tick to indicate your child’s ability 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 correct bolus</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Calculates and sets basal profiles</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 unfusion 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/caregivers 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/caregivers 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 child)

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></th>
<th>NO</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucose tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Snack</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syringes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood glucose meter</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insulin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ketone strips</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please list)</td>
<td></td>
<td></td>
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<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/Caregiver Signature:  
Date:  
Medical practitioner’s signature: (if required)  
Date: 

Review Date:  

OFFICE USE ONLY

Date received:  
Date uploaded to SEQTA:  

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, add to student file.