Child Youth & Family - *Diabetes Guidelines -* Attachment 1

Child’s family name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s given name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child require medication while in attendance at the service? Yes 🞎 No 🞎

**If yes,** please request a Diabetes medication administration form

FDC school age children:

Is the child usually able to self-manage his/ her diabetes care? Yes 🞎 No 🞎

**Insert photo of child here**

Diabetes Management Plan

|  |  |
| --- | --- |
| Medication |  |
| Name of medication: | What time is the medication administered? | How is the medication administered? |
|  |  |  |
|  |  |  |
|  |  |  |
| Medical aids used at the children’s service (blood glucose testing kit) |
| Name of aid: | Where are the aids stored in the service? |
|  |  |
|  |  |
|  |  |
| Observable signs of hypoglycaemia (a ‘hypo’) – blood glucose levels < 4.0mmol/L LOW |
| Signs and Symptoms | Causes | Prevention strategies |
|  |  |  |
|  |  |  |
|  |  |  |
| Treatment and action Steps for hypoglycaemia LOW |
| Step 1 |
| Step 2 |
| Step 3 |
| Step 4 |
| Observable signs of hyperglycaemia (a ‘hyper’) – blood glucose levels > 15mmol/L HIGH |
| Signs and Symptoms | Causes | Prevention strategies |
|  |  |  |
|  |  |  |
|  |  |  |
| Treatment and action Steps for hyperglycaemia HIGH |
| Step 1 |
| Step 2 |
| Step 3 |
| Step 4 |
| Blood Glucose Levels - routine monitoring times and action  |
|  |
|  |
|  |
| Ketone Levels - routine monitoring times and action  |
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|  |
|  |
| Food and drink requirements. Please indicate times  |
|  |
|  |
|  |
|  |
| Physical Activity Requirements |
|  |
|  |
|  |
| Authority |
| Parent signature: Date: / / |
| Doctor’s name: |
| Medical practice name, address and telephone: |
| Diabetes Risk Minimisation and Communication Plan completed Date: / / |
| Agreed review date: Date: / / |
| Medical practitioner signature: Date: / / |
| **Note: This information should be updated annually or each time your child’s Diabetes Management Plan is changed, whichever is sooner.** |
| The parent and educator are required to complete further documentation  |
| Record of Ketones |
| Record of blood sugar levels |

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