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? | | |
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| 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 |
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|  | |  | | |  |
|  | |  | | |  |
| Treatment and action Steps for hyperglycaemia HIGH | | | | | |
| Step 1 | | | | | |
| Step 2 | | | | | |
| Step 3 | | | | | |
| Step 4 | | | | | |
| Blood Glucose Levels - routine monitoring times and action | | | | | |
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| Ketone Levels - routine monitoring times and action | | | | | |
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| Food and drink requirements. Please indicate times | | | | | |
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| Physical Activity Requirements | | | | | |
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|  | | | | | |
| 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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