

Use in conjunction with Diabetes Management Plan.

This plan should be reviewed every year.

HIGH Hyperglycaemia (Hyper)

Blood Glucose Level (BGL) greater than or equal to 15.0 mmol/L is well above target and requires additional action

SIGNS AND SYMPTOMS Increased thirst, extra toilet visits, poor concentration, irritability, tiredness Note: Symptoms may not always be obvious

> IF UNWELL (e.g. VOMITING), CONTACT PARENT/CARER TO COLLECT CHILD/STUDENT

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BLOOD GLUCOSE LEVELS (BGL) TO BE CHECKED (tick all those that apply)

- Anytime hypo suspected Before snack Before lunch
- Before activity
- Before exams/tests When feeling unwell
- Beginning of a er-school care session

LOW BLOOD GLUCOSE LEVELS (Hypoglycaemia / Hypo) FOLLOW ACTION PLAN

- If the child/student requires more than 2 consecutive fast acting carbohydrate treatments, as per their Diabetes Action Plan, call their parent/carer. Continue hypo treatment if needed while awaiting further advice.
- All hypo treatment foods should be provided by the parent/carer.

SEVERE HYPOGLYCAEMIA (HYPO) MANAGEMENT FOLLOW ACTION PLAN

Is NOT common.

DO NOT attempt to give anything by mouth to the child/student or rub anything onto the gums as this may lead to choking.

If the early childhood setting/school is located more than 30 minutes from a reliable ambulance service, then sta should discuss Glucagon injection training with the child/student's Diabetes Treating Team.

HIGH BLOOD GLUCOSE LEVELS (Hyperglycaemia / Hyper) MORE THAN 15 mmol/L FOLLOW THE ACTION PLAN

KETONES FOLLOW THE ACTION PLAN

• Ketones occur most commonly in response to high glucose level and

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Page 5 of 10

NAME	
HOSPITAL UR NO	

DATE PLAN CREATED

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Page 7 of 10

NAME _____ HOSPITAL UR NO. ___

DATE PLAN CREATED

EXCURSIONS / INCURSIONS

Page 8 of 10

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AGREEMENTS

PARENT/CARER

NAME

Organise a meeting with the early childhood setting/school representatives to discuss implementation and sign o on your child's action and management plan.

- I have read, understood, and agree with this plan.
- I give consent to the early childhood setting/school to communicate with the Diabetes Treating Team about my child's diabetes management at early childhood setting/school.

FIRST NAME (PLEASE PRINT)	FAMILY NAME (PLEASE PRINT)
SIGNATURE	DATE
EARLY CHILDHOOD SETTING / SCHOOL I have read, understood, and agree NAME	
FIRST NAME (PLEASE PRINT)	FAMILY NAME (PLEASE PRINT)
·	e Principal 🔹 Centre Manager
SIGNATURE	DATE
DIABETES TREATING MEDICAL TEAM	
NAME	
FIRST NAME (PLEASE PRINT)	Family Name (Please Print)
SIGNATURE	DATE
Hospital Name	

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Page 10 of 10

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