

- This form will be completed for any child requiring testing of Blood Glucose Levels.
- An Action Plan completed by a member of the child’s healthcare team such as a specialist, GP or nurse should accompany this form.
- There must be a Risk Minimisation and Communication Plan completed together between the family and the service.

Details Must Match The Medical Action Plan Provided By The Medical Practitioner

Child’s Full Name:	
Is there a current Action Plan provided by a Medical Practitioner? Y / N	Date of Plan:
Name of Medical Practitioner:	Medical Centre Contact Details:
Name of Medical Centre or Hospital:	Reason for testing:
Has the Medical Risk Minimisation and Communication Plan been completed? Y / N	Date:
Route of Testing:	Frequency as per Action Plan:
When Suctioning should occur (Symptoms/ regular times):	

A Pharmacy/Doctor Label Must Be Affixed To The BGL Testing Machine

PARENT/GUARDIAN: I give permission for an educator to perform BGL testing as per **the instructions on the Action Plan provided by the medical practitioner or Pharmacy/Doctor Label**. I understand that, in the event of an emergency, educators will attempt to contact parents/guardians or authorised nominee as per the child’s enrolment form prior to administering however if unable to do so educators will act based on the above details. I authorise the centre to contact the Ambulance Service in the event that my child requires further medical attention and authorise the transportation and treatment as advised by Medical Staff. I accept all financial costs related to the transportation and treatment required. I understand that the health and safety of my child is the main priority at the service and as such information about my child’s allergies or serious medication conditions may be on display, including their picture and name. While this information is primarily for the educators at the service it may be viewed by students, volunteers, visitors and other families. A condition of enrolment at this service is that this information is readily available to ensure your child’s safety.

Parent/Guardian Full Name: _____ Signature: _____ Date: _____

Nominated Supervisor: _____ Signature: _____ Date: _____

BGL Checklist:

Diabetes Management Plan	<ul style="list-style-type: none"> • Is it more than 12 months old? • Are there any changes or does the plan need updating? • Are the emergency contact details up to date?
Blood Glucose, Ketones (if applicable) and Insulin monitoring chart	<ul style="list-style-type: none"> • Has a monitoring chart been sent from home? If not staff at Ruby and Ollies will maintain a record and copy will be sent to parents.
Insulin injections (pen) equipment/supplies <ul style="list-style-type: none"> • Insulin pen • Insulin pen needle • Sharps container • Insulin calculated information • Carb counting information on the food pack 	<ul style="list-style-type: none"> • Is spare insulin supplied? • Is there a sharps container? • Insulin checked, in date and no cloudy. • Insulin calculated and Carbohydrate information on food pack
Insulin pump equipment/supplies	<ul style="list-style-type: none"> • Spare pump supplies? • Has spare insulin pen and needles available as backup? • Is the machine charged and working?
Monitoring equipment/supplies <ul style="list-style-type: none"> • Blood glucose meter • Glucose test strips • Lancing device • Lancets • Ketone test strips (if applicable) • Phone or receiver for CGM data (if applicable) • Gloves 	<ul style="list-style-type: none"> • Are there spare batteries for the blood glucose meter? • Is a spare meter available if needed? • Are the blood glucose and/or ketone strips in date? • If the child is using a CGM, do they have a blood glucose meter and lancing device available?

<p>Hypo kit</p> <ul style="list-style-type: none">• Fast acting (high GI) carbohydrate• Slower acting carb (lower GI) carbohydrate (if needed)	<ul style="list-style-type: none">• Is an extra hypo kit available?• If included in the diabetes management plan, is the glucagon pen still within its use by date? While this may not be authorised to be used by staff at Ruby and Ollies, it may be sent as an emergency use to be given by the paramedics.
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Child's Full Name:

Blood Glucose Level Testing and Insulin Monitoring Form

WEEK BEGINNING: (DATE)

	Insulin Injections					Monitoring Blood Glucose								Remarks Activity, illness, diet changes, time of hypos (noting blood glucose and treatment).
	Type of Insulin	Units given				Breakfast		Lunch		Dinner		Before Supper or Bed	Over night	
		Breakfast	Lunch	Dinner	Before Bed	Before	After	Before	After	Before	After			
Mon														
Tues														
Wed														
Thu														
Fri														
Sat														
Sun														

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