TYPE TWO DIABETES MANAGEMENT PLAN: 2027

Medication (Not Insulin Injections)

CYHNCN Child & Youth Health National Clinical Network

Use in conjunction with Diabetes Action Plan.
This has been developed by specialist diabetes clinicians.

As kaitiaki (carers/guardians) of diabetes related services, it is a collective responsibility to establish an environment that facilitates a pathway for people with diabetes to navigate te ao mate huka - the world of diabetes[1].

Student's name:	Age:	Date:

MEDICATION ADMINISTRATION

The student requires diabetes medication at school: ☐ Yes ☐ No

☐ Oral medication ☐ Injection ☐ Lunchtime ☐ Other _____
(please specify):

Medication to be given _____

Please note, injections should be administered wherever the student feels comfortable.

Is supervision required ☐ Yes ☐ No ☐ Remind only

Responsible staff will need training if they are required to:

☐ Observe ☐ Assist ☐ Administer medication (dose as per additional documentation provided)

RESPONSIBLE STAFF

School staff who have voluntarily agreed to undertake training and provide support with diabetes care to the student.

List below and tick those that apply

Nominated staff members:	Glucose checking	Medication administration Supervision
	☐	☐
	☐	☐
	☐	☐
	☐	☐

☐ RESPONSIBLE STAFF

A Medical Authority Form may be required if school staff are to administer/ supervise medication.

Medication Authority Form ☐ Yes ☐ No

☐ BEFORE/ AFTER SCHOOL CARE

Before / after school care may be provided by the school, or an outside organisation. Parent / carer to obtain and complete the relevant documentation from this setting, authorising staff to administer / supervise medication administration to their child.

Student's name: _____

[1] *Te Kaiwhakahaere Māori te Roopu mate huka Debbie Rawiri- Te Whatu Ora Waitaha Canterbury*

GLUCOSE LEVEL (GL) CHECKING

Is a glucose level check required at school?

☐ Yes (See information below) ☐ No

Target range for glucose levels pre-meals: 4.0 - 7.0 mmol/L.

- Glucose levels outside this target range are common.
- A glucose check should occur where the student is at the time it is required.
- Before doing a glucose check the student should wash and dry their hands.

Is the student able to do their own glucose level check: ☐ Yes ☐ No

The responsible staff member needs to: ☐ Do the check ☐ Assist ☐ Observe ☐ Remind

Glucose Levels (GLs) to be checked (tick all those that apply)

☐ Before activity ☐ Before snack ☐ Before lunch

☐ Before exams / tests ☐ When feeling unwell ☐ Beginning or after school care

☐ Other times
(please specify): _____

_____

**The student may use a Continuous Glucose Monitoring (CGM) Device.
These are not routinely funded for type 2 diabetes.**

Student's name: _____

HIGH GLUCOSE LEVELS

(Hyperglycaemia / Hyper)

- Although not ideal, GLs above target range are common.
- If GL is 15.0 mmol/L or more, follow the student's Diabetes Action Plan.
- If the student is experiencing patterns of high GL at school, make sure the parent/carer is aware.

EATING AND DRINKING

- Seek parent/carer advice regarding foods for school parties/ celebrations.
- Always allow access to water.

SCHOOL CAMPS

It is important to plan for school camps and consider the following:

- Parents/carers need to be informed of any school camps at the beginning of the year.
- Checklists for whānau and school are available here.
- A separate and specific Camp Diabetes Management Plan is required.

EXAMS

APPLICATIONS FOR SPECIAL CONSIDERATION

Students with Type 2 diabetes mellitus who are not using rapid acting insulin are not eligible to apply to NZQA for "Special Assessment Conditions" (SAC) on medical grounds.

EXTRA SUPPLIES

Provided for diabetes care at the school by parent/carer

- ☐ Finger prick device
- ☐ Blood glucose meter
- ☐ Blood glucose monitor
- ☐ Blood glucose strips
- ☐ Sharps container

Student's name: _____

AGREEMENTS

PARENT/CARER

☐ I have read, understood and agree with this plan.

☐ I give consent to the school to communicate with the Diabetes Treating Team about my student's diabetes management at school.

First name _____ Family name _____

Signature _____ Date _____

SCHOOL REPRESENTATIVE

☐ I have read, understood and agree with this plan.

First name _____ Family name _____

Role: ☐ Principal ☐ Supervisor ☐ Manager ☐ Other _____
(please specify):

Signature _____ Date _____

This document has been developed by Specialist Diabetes Clinicians.
If you have concerns, please contact the child's diabetes treating team.

Student's name: _____