

EMERGENCY CARE PLAN FOR A DIABETIC STUDENT

NAME: _____ DOB: _____ GR: _____
TEACHER: _____
PARENT/GUARDIAN: _____ HOME PHONE: _____
MOTHER'S WORK PHONE: _____ FATHER'S WORK PHONE: _____
IF PARENT NOT AVAILABLE CONTACT: _____ PHONE: _____
DOCTOR _____ PHONE: _____

Observe for following symptoms: (Check appropriate ones.)

Hypoglycemia

- Pale and clammy Numbness or tingling of the lips
 Student expresses tiredness of _____
 Increased irritability Dizzy Poor coordination
 Headache Blurred or double vision
 Personality change usually _____
 Other _____

Hyperglycemia

- Vomiting Abdominal pain
 Extreme thirst Fruity breath
 Rapid breathing

ACTION PLAN: (Number the actions in the order you want followed.)

- If we suspect low blood sugar
 - Give sugar snack
 - Do blood glucose level
 - Call parent
 - Call doctor
- If student passes out
 - Use gel frosting along the gum line
 - Call parent
 - Call 911
 - Instruct to take to _____ (hospital).
 - Phone to hospital: _____
- If blood glucose level is under _____ mgm/ml give snack of _____.
- If blood glucose level is over _____ mgm/ml student or parent is to give insulin as directed by the doctor.

Approved by parent/guardian _____ (date) _____ (signature)

School nurse _____ (date)

Initial and date for yearly review (make corrections in red)

Parent/Guardian	Date	School Nurse	Date
Initial _____	_____	_____	_____
_____	_____	_____	_____

cc-health record
attached to H&E card
teacher