STUDENT PHOTO

DIABETES EMERGENCY CARE PLAN

For School Use Only

Location of Medication: _____ Location of Food: _____

TO BE COMPLETED BY PARENT/CAREGIVER

Name: _____ Date of Birth: _____ School: _____

Grade: _____ Homeroom Teacher: _____ Room: _____

Parent/Caregiver Name: _____ Phone (home): _____ (cell): _____

Address: _____ Phone (work): _____ Email: _____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Health Care Provider Treating Student for Diabetes: _____ Ph: _____

SIGNS OF HYPOGLYCEMIA: Headache, tremors, cold sweat, hunger, irritability, nervousness, pale skin, confusion, drowsiness, weakness or fatigue, dizziness, poor coordination, inability to concentrate, slurred speech, combativeness, uncooperativeness, convulsions, unconscious.

Hypoglycemia: Blood Glucose less than _____

Carbohydrate Source:_____
Give #gms_____ for Blood Glucose less than_____

Glucagon: IM or SQ Dose:_____

Administer Glucagon when:_____

CALL 911 IF ADMINISTERING GLUCAGON and/or for: _____

SIGNS OF HYPERGLYCEMIA: Increased urination, increased thirst, blurred vision, increased hunger, fruity breath, vomiting, stomach pain, weakness, sleepiness, difficulty breathing, coma

Hyperglycemia: Blood glucose greater than _____

Treatment for Hyperglycemia: _____

_____

Student can return to regular activities including PE when: _____

CALL 911 WHEN: _____

_____

Contact parent/caregiver when blood glucose is less than_____or greater than_____

Notify parent/guardian and document what happened in the First Aid and Medication Logs.
***By law, a completed and signed Medication Form must be on file at the school before medication can be administered at school.**

I authorize school personnel to implement this Diabetic Emergency Plan as described above.
I have completed the medication form(s) FOR EACH medication that might be given at school.

_____ _____
Health Care Provider Signature & NPI # **Date**

I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent for school authorities to communicate with the authorized health care provider when necessary.

_____ _____
Parent/Caregiver Signature **Date**