

DIABETES EMERGENCY CARE PLAN

Pleasantdale District 107

Student Name:		Teacher/Team:	
Grade:	DOB:		

Emergency Contacts:

	Name	Relationship	Home Phone	Work Phone	Cell Phone
1					
2					
3					

Physician:	Phone:
Hospital:	Phone:

Health Concern:

Allergies:

Diabetic History:
Maintenance Regimen:

1. RECOGNIZE SIGNS OF ALTERED BLOOD SUGAR LEVELS

IF CHILD UNCONSCIOUS

- Activate EMS – 911
- Notify health office
- Administer medications as ordered
- LSN to administer glucagon as ordered
- Notify Primary Emergency Contact
- Stay with child and reassure until ambulance arrives

For any of the following symptoms send child with an escort to the Health Office for observation and treatment:

Hypoglycemia / low blood sugar		Hyperglycemia / high blood sugar	
shaky/trembling	difficulty with coordination	increased thirst/urination	loss of appetite
dizzy	confused/disoriented	weakness	nausea and vomiting
pale	severe headache	abdominal pain	heavy/labored breathing
irritable	impaired vision	generalized aches	
weak/drowsy	sweaty		

2. TEST BLOOD SUGAR

- Blood sugar below _____ follow: **3. Low Blood Sugar Flow Chart**
- Blood sugar over _____ follow: **4. High Blood Sugar Flow Chart**

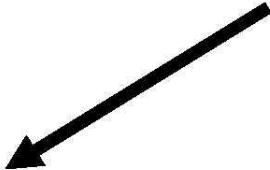
3. LOW BLOOD SUGAR FLOW CHART (HYPOGLYCEMIA)

*Blood Sugar < _____



Administer 1 Carbohydrate Choice _____

Retest Blood Sugar in 15 minutes



*** NOTIFY PARENT FOR:**

- Blood sugar < _____ and after treatment is initiated
- Failure to attain normal blood sugar after _____ cycles of treatment

*** NOTIFY LSN FOR:**

- Blood sugar < _____ after _____ cycles of treatment
- Signs of low blood sugar _____

*Repeat cycle until blood sugar is > _____

4. HIGH BLOOD SUGAR FLOW CHART (HYPERGLYCEMIA)

Blood Sugar > _____



A. Notify parent and Health Office
B. Test for ketones if supplies available
C. Additional insulin as ordered
D. Have student drink 8 oz. Water



Retest and treat per parent/doctor's orders

In case of serious illness and I cannot be reached I authorize school personnel to contact:

Physician/Clinic: _____

or transport by ambulance to: _____

Hospital

I agree with this emergency care plan for my child. I give permission for this plan to be carried out and shared with pertinent staff during the current school year.

Parent Signature: _____ **Date:** _____

MD Signature: _____ **Date:** _____

Note: Per school district policy, signed physician prescription, parent authorization, and medication in the original container are required for any medication administration at school.

for school use only:

Insulin: _____ Date received in health office: _____

Date physician orders received: _____

Glucagon: _____ Date received in health office: _____

Date physician orders received: _____

Diabetic supplies in Health Office: _____ Date received in health office: _____