DIABETES - Emergency Care Plan Utah Department of Health	School Year:	Picture

STUDENT INFORMATION			
Student:	DOB:	Grade:	School:
Parent:	Phone(s):		Email:
Physician:	Phone:		Fax or email:
School Nurse:	School Phone:		Fax or email:

When Blood Glucose is in Target Range (or between _____ and _____)

Student is fine

HYPOGLYCEMIA – When Blood Glucose is Below 80 (or below _____)

Causes: too much insulin; missing or delaying meals or snacks; not eating enough food; intense or unplanned physical activity; being ill.

Onset: sudden, symptoms may progress rapidly

MILD OR MODERATE **HYPOGLYCEMIA**
Please check previous symptoms

☐ Anxiety	☐ Hunger	☐ Shakiness
☐ Behavior change	☐ Headache	☐ Slurred speech
☐ Blurry Vision	☐ Irritability	☐ Sweating
☐ Confusion	☐ Paleness	☐ Weakness
☐ Crying	☐ Personality change	☐ Other:
☐ Dizziness	☐ Poor concentration	
☐ Drowsiness	☐ Poor coordination	

SEVERE **HYPOGLYCEMIA**
Please check previous symptoms

☐ Combative
☐ Inability to eat or drink
☐ Unconscious
☐ Unresponsive
☐ Seizures
☐ Other:

ACTIONS FOR MILD OR MODERATE **HYPOGLYCEMIA**

1. Give student fast-acting sugar source
2. Wait 15 minutes.
3. Recheck blood glucose.
4. Repeat fast-acting sugar source if symptoms persist OR blood glucose is less than 80 or _____
5. Other:

ACTIONS FOR SEVERE **HYPOGLYCEMIA**

1. Don't attempt to give anything by mouth.
2. Position on side, if possible.
3. Contact trained diabetes personnel.
4. Administer glucagon, if prescribed.
5. **Call 911**. Stay with student until EMS arrives.
6. Contact parents/guardian.
7. Stay with student.
8. Other:

FAST ACTING SUGAR SOURCES (15 grams carbohydrates): 3-4 glucose tablets **OR** 4 ounces juice **OR** 0.9 ounce packet of fruit snacks

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Student Name:	**DOB:**

HYPERGLYCEMIA - When Blood Glucose is over 250 (or above _____)

Causes: too little insulin; too much food; insulin pump or infusion set malfunction; decreased physical activity; illness; infection; injury; severe physical or emotional stress.

Onset: over several hours or days.

MILD OR MODERATE **HYPERGLYCEMIA** Please check previous symptoms		SEVERE **HYPERGLYCEMIA** Please check previous symptoms	
☐ Behavior Change ☐ Blurry Vision ☐Fatigue/sleepiness ☐Frequent Urination	☐ Headache ☐ Stomach pains ☐ Thirst/dry mouth ☐ Other:	☐Blurred vision ☐ Breathing changes (Kussmaul breathing) ☐ Chest pain ☐ Decreased consciousness ☐ Increased hunger	☐ Nausea/vomiting ☐ Severe abdominal pain ☐ Sweet, fruity breath ☐ Other:

ACTIONS FOR MILD OR MODERATE **HYPERGLYCEMIA**	ACTIONS FOR SEVERE **HYPERGLYCEMIA**
1. Allow liberal bathroom privileges. 2. Encourage student to drink water or sugar-free drinks. 3. Administer correction dose if on a pump. 4. Contact parent if blood sugar is over _____ mg/dl. 5. Other:	☐ Administer correction dose of insulin if on a pump ☐ Call parent/guardian. ☐ Stay with student ☐ Call 911 if patient has breathing changes or decreased consciousness. Stay with student until EMS arrives ☐ Other:

INSULIN PUMP FAILURE (please indicate plan for insulin pump failure)

☐ NA/not on an insulin pump ☐administer insulin via syringe/vial or pen ☐parent to come and replace site
☐ School nurse can replace site (only if previously trained)
☐ student can replace site alone or with minimal assistance ☐ Other:

Never send a child with suspected low blood glucose anywhere alone!!!

PARENT SIGNATURE

I have read and approve of the above emergency care plan.

Parent:	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:

SCHOOL NURSE

Copies of this Emergency Care Plan distributed to 'need to know' staff: ☐ Classroom Teacher(s)
☐ PE Teacher(s) ☐ Office staff/administration ☐ Transportation ☐ Other (specify):

School Nurse Signature:	**Date:**