Diabetes Healthcare
Emergency Action Plan

Student's Name _____ Grade _____

Address _____ Home Phone _____

Father/Guardian _____ Work Phone _____

Mother/Guardian _____ Work Phone _____

Other person to contact in an Emergency: Name_____

Address_____

Phone: Home _____ Work _____

Hospital Preferred _____

Physician(s) or Health Care Provider's Name _____

Phone _____

Emergency items to be left at school:

Glucose tablets _____ Glucagon_____

Snacks_____ Blood glucose meter_____

Glucose Gel _____ Insulin _____

_____ Syringes _____

_____ Other _____

In the event of a low blood sugar response, the procedure routinely followed at school is: to give some form of sugar or carbohydrate, such as ½ carton of milk, ½ cup fruit juice or ½ cup non diet soda, followed by crackers with cheese. If the student is unconscious, "911" is called.

I above the above health care action plan as written Yes ____ No ____

Please make the following changes to the health care action plan:

_____
_____
_____
_____
_____
_____
_____

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List other additional information or significant special health concerns of this student

_____
_____
_____
_____
_____

I give permission for emergency blood glucose testing by the school nurse or designee using equipment I have provided. I understand that when the school nurse or designee is not available for emergency blood glucose testing, the parent/guardian will be notified or "911" will be called. Yes ____ No _____

Additional directions regarding blood glucose testing: _____

_____
_____
_____

Written and submitted by: _____ _____
Nurse or Designee Date

Reviewed and signed: _____ _____
Parent/guardian Date

_____ _____
Student Date

_____ _____
Physician or Health Care Provider Date

To be reviewed _____
Date

Healthcare plan should be revised according to child's specific needs, at least annually.