DIABETES EMERGENCY CARE PLAN

Minnetonka School District

School: School Health Services **School Year:**

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

Shaky/trembling
Dizzy
Pale
Irritable
Weak/drowsy
Difficulty with coordination
Confused/disoriented
Severe headache
Impaired vision
Sweaty

Hyperglycemia/high blood sugar

Increased thirst/urination
Weakness
Abdominal pain
Generalized aches
Loss of appetite
Nausea and vomiting
Heavy/labored breathing

2. TEST BLOOD SUGAR

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

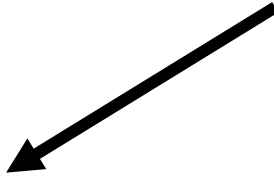
3. LOW BLOOD SUGAR FLOW CHART (HYPOGLYCEMIA)

*Blood Sugar < _______

Administer 1 Carbohydrate Choice

____

____



Retest Blood Sugar in 15 minutes

*Repeat cycle until blood sugar is >______

* **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 ______

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. A designation of ECP (Emergency Care Plan) will appear in the alert box found within the Skyward emergency tab.

Parent Signature: ______________________________ **Date:** ______________

LSN 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. See medication form K-5 or 6-12.

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: __________