

# EMERGENCY CARE PLAN

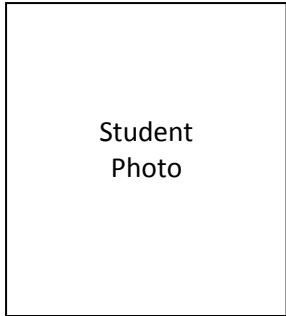
## DIABETES - HYPERGLYCEMIA



Student: \_\_\_\_\_ Grade: \_\_\_\_\_ School Contact: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Mother: \_\_\_\_\_ M Home #: \_\_\_\_\_ M Work #: \_\_\_\_\_ M Cell #: \_\_\_\_\_  
 Father: \_\_\_\_\_ F Home #: \_\_\_\_\_ F Work #: \_\_\_\_\_ F Cell #: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**SYMPTOMS OF A HYPERGLYCEMIC EPISODE MAY INCLUDE ANY/ALL OF THESE:**

- Gradual Onset
- Extreme thirst, very frequent urination, drowsiness
- Flushed skin, heavy breathing, blurred vision
- Vomiting, fruity or wine-like odor to breath



**SEVERE SYMPTOMS INCLUDE:**

- Stupor
- Unconsciousness

**STAFF MEMBERS INSTRUCTED:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Classroom Teacher(s) | <input type="checkbox"/> Special Area Teacher(s) |
| <input type="checkbox"/> Support Staff  | <input type="checkbox"/> Support Staff        | <input type="checkbox"/> Transportation Staff    |

**TREATMENT:**

Stay with the student.  
 Notify school nurse immediately.  
 Call 911 to access Emergency Medical Services – transport to hospital by ambulance  
 Preferred Hospital if transported: \_\_\_\_\_

Notify parents / guardian (do not delay treatment by calling – obtain treatment for student first).

Healthcare Provider: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Written by: \_\_\_\_\_ Date: \_\_\_\_\_

- Copy provided to Parent                       Copy sent to Healthcare Provider

**Parent/Guardian Signature** to share this plan with Provider and School Staff: \_\_\_\_\_

*This plan is in effect for the current school year and summer school as needed.*