HYPOGLYCEMIA (Non-Diabetic) Emergency Action Plan

NAME: _____ Date of Birth: _____

School: _____ Grade: _____ Homeroom Teacher:_____

Contact Information:
Parent/Guardian: _____ Telephone # (w) _____
Address: _____ Telephone # (h) _____
Emergency Contact: _____ Telephone # _____

Physician Treating Student: _____ Telephone # _____
Other Physician: _____ Telephone # _____

EMERGENCY PLAN **(Fill in blanks, cross out and initial any steps not needed for this student.)**

- **Signs and Symptoms of Hypoglycemia:**
- **Headache / Impaired Vision**
- **Irritability / crying / confusion / anxiety**
- **Tremors / shaking / dizziness**
- **Hunger**
- **Rapid Pulse**
- **Cold / moist skin**
- **Fatigue**
- **Other symptoms for this student: _____**

- **Time student is most likely to experience low blood sugar: _____**

- **Are snacks required between meals? _____ If yes, snack times: _____**
  (Parent must provide snack.)

- **Will student need to monitor blood sugar at school? _____ If yes, time to monitor: _____**
  (Authorization for Procedure at School must be completed by healthcare provider and parent)

- **Steps to treat low blood sugars:**
- **Administer fast acting sugar source: _____.**
- **Do not leave student unattended until symptoms are resolved.**
- **If symptoms do not resolve within _____ minutes, contact parent to transport home.**
- **If student becomes unconscious, call 911 immediately!!**

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Review Date_____

THIS INFORMATION WILL BE SHARED WITH APPROPRIATE SCHOOL STAFF UNLESS OTHERWISE STATED.