Chatfield Public Schools, I.S.D. #227
Chatfield, Minnesota

DIABETES MELLITUS EMERGENCY PLAN School Year_____

Student's name_____ DOB _____ Grade _____

Parent/guardian _____ Home phone _____

Mother's work phone_____ Father's work phone_____

Mother's cell phone_____ Father's work phone_____

Other emergency contact if above unavailable _____

Relationship_____ Phone _____

In case of a diabetic emergency and parent/guardian cannot be reached, I authorize school personnel to contact the following physician/clinic for diabetic management**:**

_____ Phone _____

Preferred hospital in case of emergency _____

Daily management regimen (type of insulin or oral agent, dosage and times) _____

_____

Does child routinely need assistance with glucose monitoring or insulin administration?

Yes _____ No _____ Comments _____

Acceptable blood glucose range for my child is _____

Please notify parent/guardian if blood glucose is less than_____ or higher than_____

List signs/symptoms of an insulin reaction that your child may experience _____

I have reviewed the diabetes mellitus emergency plan. I will notify the school nurse of any changes in the student's diabetic management.

Parent/guardian signature_____ Date _____

School Nurse signature_____ Date_____

Medication (if part of the plan) and authorization form received (date/initials)_____

Parent/guardian signature_____ Date_____

School Nurse signature_____ Date_____

Medication (if part of the plan) and authorization form received (date/initials)_____

(rev. 9/06)

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Listed below is the procedure that school personnel will follow in the event of a ***hypoglycemic (low blood glucose) reaction:***

1. Student will be accompanied to the health office.

2. The blood glucose will be checked prior to administration of a sugar source, unless the student is exhibiting signs/symptoms of a serious insulin reaction.

3. If the blood glucose is below _____, the following source of sugar (provided by the parent/guardian) is to be administered (please number in order to be given):

   _____ Juice (apple, grape, or orange—please circle if preference)--amount? _____

   _____ Glucose tablets—number? _____

   _____ Glucose gel—amount? _____

   _____ Other/Special Instructions_____

4. Student will be observed in the health office and blood glucose rechecked in 15 minutes.

5. The student will normally be allowed to return to class if the blood glucose is 70 or above. If you wish otherwise, please specify _____

6. If student's blood glucose &/or symptoms are not improving, a second sugar source will be administered and the blood glucose rechecked in 15 minutes.

7. ***If student is not responding to sugar given orally, or he/she becomes disoriented or unconscious, 911 will be called, an ambulance requested, and the parent/guardian notified.***

If the student becomes unconscious and the parent/guardian wishes Glucagon to be administered by injection, it must be understood that ***a nurse is not always available.***

I want_____ do NOT want_____ Glucagon to be part of my child's treatment plan and administered if a nurse is available. If Glucagon is to be administered, the medication must be provided and a separate medication authorization form completed.

Please describe the procedure you would like school personnel to follow in the event of a ***hyperglycemic (high blood glucose)reaction***

Please provide any additional information or special requests regarding the emergency plan