Diabetes Emergency Healthcare Plan (ECP)

Student Name: _____ Date: _____

Birth date: _____ Student ID No. _____ Grade/Room: _____

Parent/Guardian Name: _____ Phone: (____)_____

Emergency Contact: _____ Phone: (____)_____

Emergency Contact: _____ Phone: (____)_____

Health Care Provider: _____ Phone: (____)_____

Hospital in case of emergency: _____ **Emergency supplies located**: _____

*** Never send a child with suspected low blood sugar anywhere alone.**

SYMPTOMS*
Low Blood Sugar
Less than: _____

MILD
Hunger
Irritable
Weak
Pallor
Crying
Sweating
Unable to concentrate
Other: _____
Dizziness
Shakiness
Anxious
Drowsy
Headache

MODERATE
Sleepiness
Erratic behavior
Confusion
Slurred speech
Poor coordination

SEVERE
Unable to swallow
Combative
Unconscious
Seizures

ACTION
- **Treat symptoms as listed below**
- **Check Blood Sugar**
- **Notify School Nurse:**

Name: _____
Pager: _____

MILD
- ☐ Provide sugar source:
  - 2-3 glucose tabs
  - 4 oz juice
  - 4 oz regular soda or glucose gel
- ☐ Wait 10 to 15 minutes
- ☐ Retest blood glucose. If less than _____mg/dl, retreat with sugar source.
- ☐ If blood sugar within target range: _____mg/dl, student may return to class.

MODERATE
- ☐ Provide sugar source:
  - 2-3 glucose tabs
  - 4 oz juice
  - 4 oz regular soda or glucose gel
- ☐ Wait 10 to 15 minutes
- ☐ Retest blood glucose. If less than _____mg/dl, retreat with sugar source.
- ☐ Notify Parent or guardian.
- ☐ Provide snack if no meal for more than 1hour.
- ☐ If blood sugar within target range: _____mg/dl, student may return to class if feeling better.

SEVERE
- ☐ **Call 911**
- ☐ Give Glucagon, if ordered.
- ☐ Position on side
- ☐ Contact Parent/Guardian & School Nurse

Licensed School Nurse Signature: _____ Date plan developed: _____

Copy(ies) given to: _____ Date _____

Adapted from P.E.D.S, 200