Whitehall-Coplay School District

Emergency Action Plan (EAP) ~ Diabetes

Place Child's Photo Here

Student: _____ Date: _____
Teacher/Classroom: _____ Bus: _____
Diagnosis: _____

Signs of Low Blood Sugar

(hypoglycemia)

(too little food, too much insulin, too much exercise)

- **shaking** **sweating** **anxious** **dizziness**
- **hunger** **blurry vision** **weakness/fatigue** **headache**
- **irritability** **tingling/numbness of lips and tongue**

Other known symptoms: _____

Treatment

1. Give glucose tablet, juice, milk
2. Do not move student; remain with student
3. Notify school nurse/parent
4. If becomes groggy but is still responsive and able to swallow

*Give 1 tablespoon of glucose gel or frosting inside the lower lip and massage gently.

5. If unable to swallow and unresponsive:

*** Call 9-911**

* The nurse or trained school personnel will administer:
Glucogon _____ intramuscularly.
(dosage)

* Place student on side and remain with student.

Signs of High Blood Sugar

(Hyperglycemia)

(too much food, too little insulin, illness, stress)

extreme thirst frequent urination dry skin drowsiness nausea

Treatment

1. _____
2. _____

Emergency Calls

1.Parent/guardian: _____

_____

2. Additional emergency contacts: _____

3. Physician: _____

Parent/Guardian Signature: _____ Date: _____
Physician Signature: _____ Date: _____
School Nurse: _____ Date: _____
School personnel informed: _____ Date: _____

Care plans are updated yearly and/or throughout the school year as needed.

WHITEHALL-COPLAY SCHOOL DISTRICT

Medication Dispensing Form

To the Physician:

Please *complete* and *sign* this form if you request your patient to receive a medication during school hours. By signing this form, you are indicating that the student could not attend school unless this medication was available during the school day.

Medication must be brought in the original bottle and will be kept in the health room. It will be the student's responsibility to request the medication in the health room.

Student's name: _____ Grade: _____ Teacher: _____

Prescribed medication: _____

Dosage*, route, and frequency: _____

Time of day to be given: _____

Reason for medication: _____

Side effects: _____

Is child taking any other medication? Name? _____

This authorization is in effect from: _____ to: _____**

☐ **Student may carry INHALER / EPIPEN (circle choice) and use as prescribed by licensed provider.**

***Licensed Prescriber signature**: _____ Date: _____

Print name of Licensed Prescriber: _____

Telephone # of Licensed Prescriber: _____

I do hereby release, discharge, and hold harmless, the Whitehall-Coplay School District, its agents and employees, from any and all liability claim for the administration of the above medication to my child and for any and all injuries resulting there from. I consent for employees of Whitehall-Coplay School District to exchange information regarding this medication with the physician who ordered the medication. Please refer to the school calendar for policies related to medications.

Parent /Guardian signature: _____ Date: _____

If the dosage is changed at any time, physician must complete new form. Please request additional forms as needed from the school nurse or obtain on-line at www.whitehallcoplay.org.

****This form is only valid for school year in which it was completed.***

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