



Diabetes Emergency Action Plan

TO BE COMPLETED BY A LICENSED HEALTHCARE PROFESSIONAL

Student: _____ DOB: _____ School: _____ Grade: _____
Type _____ Diabetes Year of Diagnosis: _____ This plan is valid only for the school year: _____ - _____

Student is to test blood sugar: ☐ Before Breakfast ☐ Before lunch ☐ 2 hours after lunch ☐ Before exercise
☐ After exercise ☐ Before snack ☐ Before getting on bus # _____ ☐ As needed for signs/symptoms of low/high blood sugar
-NO exercise if student is below _____ mg/dl or above _____ mg/dl
-Target Blood Sugar Range _____ mg/dl
-Contact Parent if Blood Sugar is above _____ mg/dl or below _____ mg/dl.
-Student cannot ride the bus if Blood Sugar is above _____ mg/dl or below _____ mg/dl.

GLUCAGON ADMINISTRATION ☐ 0.5 mg (less than age 10) ☐ 1.0 mg (more than age 10) ☐ Baqsimi 3mg/actuation

INSULIN ADMINISTRATION ROUTE: ☐ Pen ☐ Injection ☐ Pump; Brand _____ ☐ If pump fails use sliding scale

Type of Insulin: _____ **For Sliding Scale insulin dosage and blood sugar correction. ONLY to be used every 2 hours.**

☐ Parent/guardian authorized to increase/decrease sliding scale within the following range: +/- 2 units of insulin.

Give insulin ☐ Before Breakfast ☐ After Breakfast ☐ Before Lunch ☐ After Lunch ☐ Before AM Snack ☐ After AM Snack

☐ Before PM snack ☐ After PM snack

Blood sugar range _____ mg/dl Administer _____ units

Blood sugar range _____ mg/dl Administer _____ units

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**** IF BLOOD SUGAR IS GREATER THAN _____ mg/dl, check ketones. *Parent/guardian shall provide ketone testing supplies.**

INSULIN/CARBOHYDRATE RATIO

- Breakfast: 1 unit of insulin per _____ grams of carbohydrates.
- Mid-morning snack: 1 unit of insulin per _____ grams of carbohydrates.
- Lunch: 1 unit of insulin per _____ grams of carbohydrates.
- Afternoon snack: 1 unit of insulin per _____ grams of carbohydrates.

☐ Parent/guardian authorized to increase or decrease insulin to carbohydrate ration within 1 unit per prescribed grams of carbohydrates +/- 5 grams of carbohydrates.

CONTINUOUS GLUCOSE MONITOR

Continuous Glucose Monitor: Yes ☐ No ☐ Type _____

Note: Confirm results with blood glucose meter check before taking action on sensor blood glucose level. IF student has symptoms or signs of hypoglycemia, check fingertip blood glucose level regardless of CGM.

STUDENT'S SELF CARE – Healthcare Provider shall check all that apply.

- ☐ Totally independent management.
- ☐ Administers insulin independently.
- ☐ Tests blood sugar independently.
- ☐ Independently counts carbohydrates.
- ☐ Monitors own snacks and meals.
- ☐ Self treats mild hypoglycemia.
- ☐ Tests and interprets urine blood ketones.
- ☐ Needs verification of blood sugar by staff.
- ☐ Tests blood sugar with implanted monitor.
- ☐ Self injects with verification of dose.
- ☐ Self injects with trained staff supervision.
- ☐ Injections to be done by trained staff.

Diabetes Emergency Action Plan

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IF STUDENT IS SYMPTOMATIC, THEY SHOULD NOT BE LEFT ALONE.

HYPOGLYCEMIA: Blood Sugar LESS than _____ mg/dl

Signs/Symptoms of Hypoglycemia

*Dizziness	*Hunger	*Headache	*Loss of consciousness	*Shaking	*Blurry Vision
*Anxiety	*Weakness	*Fatigue	*Behavior Changes	*Pallor	*Seizure

1. Check blood sugar. If meter is not available and child has any of the above symptoms, proceed to step 2.
2. If blood sugar is less than _____ mg/dl: Treat with 15 grams of fast acting carbohydrate (4 oz juice, 6 oz regular soda, 3 sleeves of Smarties, etc.).

→ If unable/unwilling to take fast acting carbohydrate, having a seizure, or is unconscious: Administer **Glucagon** if ordered, turn student on left side (if able), call 911 and contact parent/guardian.
4. Recheck and retreat every 15 minutes until blood sugar is greater than _____ mg/dl.
5. When blood sugar is above _____ mg/dl, give a complex carbohydrate (cheese crackers, peanut butter crackers, etc) if it is going to be more than an hour till their next meal or snack.

HYPERGLYCEMIA: Blood Sugar GREATER than _____ mg/dl

Signs/Symptoms of Hyperglycemia

*Increased Thirst	*Hunger	*Irritability	*Nausea/Vomiting	*Double Vision
*Frequent Urination	*Fatigue	*Abdominal pain		

1. Check blood sugar.
2. If blood sugar is over _____ mg/dl and greater than 2 hours since last insulin dose, give insulin per sliding scale or bolus via pump.
3. Check ketones if ordered and equipment available. If ketones are present, call parent/guardian. Student should not exercise.
4. Give 8-16 oz. of water per hour.
5. Recheck blood sugar in 2 hours and treat with sliding scale insulin as needed.
* **When student has insulin pump:** blood sugar greater than _____ mg/dl with ketones OR 2 consecutive unexplained blood sugars greater than _____ mg/dl (with or without ketones), may indicate a malfunction in the pump. Student may require insulin via injection and/or new infusion site. **Parent/Guardian must be notified.**
6. When having symptoms of nausea/vomiting, student will be released from school to parent/guardian.

I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school and the ability to self-carry if deemed appropriate by the prescribing provider. I release the school board and their agents and employees from all liability that may result from my child taking the prescribed medication. I authorize the school nurse to communicate with the health care provider as allowed by HIPPA.

Parent/Guardian: _____ Date: _____ Phone: _____

Physician: _____ Date: _____ Phone: _____

School Nurse: _____ Date: _____ Phone: _____