

**CARE FOR STUDENTS WITH DIABETES**

**Emergency Plan for:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Division:** \_\_\_\_\_

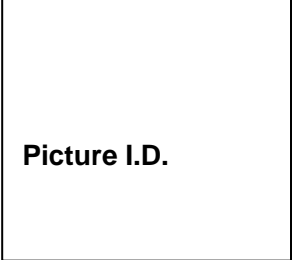
Date of Birth: \_\_\_\_\_  
y/m/d

Emergency Contact: \_\_\_\_\_  
Surname first name

Phone: \_\_\_\_\_  
cell home work

Relationship to Student: \_\_\_\_\_

Physician: \_\_\_\_\_



**HISTORY**

When was student diagnosed with diabetes? \_\_\_\_\_

How often does the student have a low blood sugar reaction? \_\_\_\_\_

Morning snack and time it is taken: \_\_\_\_\_ Afternoon snack and time it is taken: \_\_\_\_\_

\_\_\_\_\_

parent has spoken with teacher regarding child's care

student wears a Medic Alert bracelet/necklace

**CHECK USUAL SYMPTOMS OF LOW BLOOD SUGAR**

- |   |   |
|---|---|
| <input type="checkbox"/> Irritability-mood changes-crying | <input type="checkbox"/> Sweating-cold moist skin |
| <input type="checkbox"/> Headache                         | <input type="checkbox"/> Dizziness                |
| <input type="checkbox"/> Tremors-shaky body parts         | <input type="checkbox"/> Tired and pale           |
| <input type="checkbox"/> Hunger or nausea                 | <input type="checkbox"/> Other _____              |

**EMERGENCY TREATMENT**

If a reaction occurs, **GIVE SUGAR IMMEDIATELY:** 4 oz. fruit juice/pop (not diet)  
 or 2 tsp. Sugar, glucose gel or 2 glucose tablets  
 or the recommendation of the child's physician

Dial 911 if symptoms do not disappear within 15 minutes or child is unconscious.

Notify parents.

Location of emergency kit \_\_\_\_\_

Name of person completing form: \_\_\_\_\_ Parent/Guardian  Student  Other

Date form completed: \_\_\_\_\_