

**CLOVIS MUNICIPAL SCHOOLS
DIABETES EMERGENCY RESPONSE PLAN**

This Emergency Response Plan is to be completed and signed by the child's parent/guardian and physician. The information on this plan is confidential. All staff that cares for your child will have access to this information in order to provide optimal safety in the school setting. Please contact the school at any time if you need to update this Emergency Response Plan.

Student Name _____ DOB _____ Grade _____

Parent/Guardian Name _____ Ph: (h) _____

Address _____ Ph: (w) _____ Ph: (c) _____

Parent/Guardian Name _____ Ph: (h) _____

Address _____ Ph: (w) _____ Ph: (c) _____

Emergency Phone Contact #1 _____

Name Relationship Phone #

Emergency Phone Contact #1 _____

Name Relationship Phone #

Physician Treating Student for Diabetes _____

Name Phone #

Other Physician _____

Name Phone #

MILD LOW BLOOD SUGAR – treat when blood sugar is **below** _____.

Symptoms - (circle all that apply): hunger, irritability, shakiness, sleepiness, sweating, pallor, lack of cooperation, behavior changes

Additional Symptoms - _____

Treatment - **** NEVER leave student unattended.** If treatment is to be provided in the Health Room, a responsible adult should accompany the student from the classroom to the Health Room.

- Test blood sugar. If equipment is unavailable, treat immediately for low blood sugar.
- If blood sugar is below _____, give ½ cup of juice, regular soda or 3-4 glucose tablets.
- Wait 10-15 minutes. Recheck blood sugar. If blood sugar below _____, repeat juice, soda or glucose tablets as above.
- If blood sugar above _____, give snack or lunch. Make sure student is stable before sending to lunch.
- Notify school nurse and parent.

Other Instructions - _____

MODERATE LOW BLOOD SUGAR – treat when blood sugar is **below** _____.

Symptoms – (circle all that apply): same as symptoms of mild low blood sugar plus may be disoriented, combative or incoherent.

Additional Symptoms - _____

Treatment - **** NEVER leave student unattended.** If treatment is to be provided in the Health Room, a responsible adult should accompany the student from the classroom to the Health Room.

If conscious but unable to effectively drink fluids:

- Give ½ to 1 tube of Glucose Gel, or ½ to 1 tube of cake decorating gel.
- Place gel between cheek and gum with head elevated. Massage outside of cheek to facilitate absorption through the cheek membrane. Encourage student to swallow.

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MODERATE LOW BLOOD SUGAR (continued)

- Recheck blood sugar in 10 minutes. If still below _____, re-treat as above.
- Give snack when alert and able swallow without difficulty.
- Notify school nurse and parents.

Other Instructions - _____

SEVERE LOW BLOOD SUGAR

Symptoms – (circle all that apply): seizures, loss of consciousness, inability/unwillingness to take gel or juice

Additional Symptoms - _____

Treatment - **** NEVER leave student unattended.**

- Stay with the student
- Position student on his/her side
- Give Glucagon by injection; dose _____
- Call 911
- Notify school nurse and parents.

Other Instructions - _____

HIGH BLOOD SUGAR – treat when blood sugar is above _____.

Call parent/guardian when blood sugar is above _____.

Symptoms – (circle all that apply): extreme thirst, headache, abdominal pain, nausea, frequent urination

Additional Symptoms - _____

Treatment – **** NEVER leave student unattended.** If treatment is to be provided in the Health Room, a responsible adult should accompany the student from the classroom to the Health Room.

- Increase water intake
- Allow student to use restroom as often as necessary
- Check urine for ketones if sugar is greater than _____ or when ill. IF urine ketones are present, call parent immediately.
- Student or other trained personnel should administer insulin as ordered in the Diabetic Action Plan.
- If students exhibits nausea, vomiting, stomachache or is lethargic – notify the school nurse and parent immediately.

Other Instructions - _____

I give permission for school personnel to release a copy of this Emergency Response Plan to emergency personnel in the event it is necessary to activate Emergency Medical Services and/or transport my child to the hospital.

Parent Signature _____ **Date** _____

Physician Signature _____ **Date** _____

➡➡➡ Please also complete the Diabetes Action Plan. Thank you.