SUMTER COUNTY SCHOOLS HEALTH SERVICES
EMERGENCY ACTION PLAN – DIABETES
(To be completed by Registered Nurse) **SCHOOL** _____

Grade _____ **Teacher** _____ **Date Initiated** _____
Grade _____ **Teacher** _____ **Date Reviewed** _____
Grade _____ **Teacher** _____ **Date Reviewed** _____

Length of time condition has existed_____. **Date Discontinued** _____

Name: _____ **DOB:** _____
Parent #1: _____ **Phone #1:** _____ **Phone #2:** _____
Parent #2: _____ **Phone #1:** _____ **Phone #2:** _____
Emergency Contact #1: _____ **Phone:** _____
Emergency Contact #2: _____ **Phone:** _____
Physician Name: _____ **Phone:** _____
Specialist Name: _____ **Phone:** _____

Allergies to:

☐ Food _____ ☐ Medication _____
☐ Insect's _____ ☐ Other _____

Medications at School	Medication Storage Location
	☐ Clinic/Health room
	☐ Classroom
	☐ Self-Carry/Backpack
	☐ Other

Description: A chronic disease that impairs the body's ability to use food for energy, causing a need to achieve a balance between insulin therapy, diet, and activity. TARGET RANGE _____ **mg/dl**

SYMPTOMS OF LOW BLOOD SUGAR (HYPOGLYCEMIA)

MILD: Hunger, Sweating, Weakness, Irritability, Headache, Shakiness, Dizziness

MODERATE: Slurred Speech, Confusion, Blurred Vision, Behavior Changes, Sleepiness

SEVERE: Combative, Seizures, Unable to Swallow, Unconscious

MANAGEMENT OF "MILD" OR "MODERATE" LOW BLOOD SUGAR
Notify school nurse
Give 15 grams of fast acting sugar as directed by doctor's orders.
- 4 oz. juice
- 3-4 glucose tabs
- 6 oz. **regular** soda

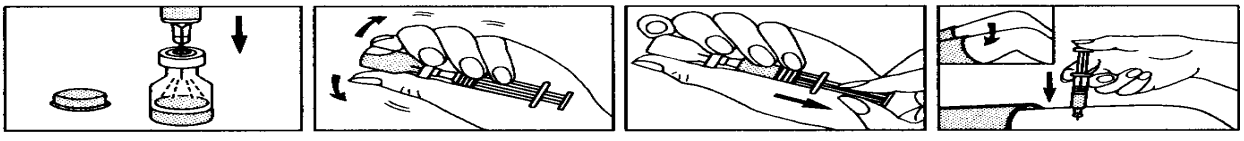
Check blood sugar
Wait 10- 15 minutes, recheck blood sugar
If in target range, stop treating and give student a 15 gram snack
If below target, give another 15 grams of a fast acting sugar and re-check blood sugar in 10-15 minutes
Notify parent

MANAGEMENT OF "SEVERE" LOW BLOOD SUGAR
Treat as above unless **student is unconscious** then, Give
Glucagon immediately **Route SQ___ Amount:** _____
*****Call 9-1-1 immediately**
Start CPR, if needed
Notify school nurse, administration and parents
If student becomes unconscious call 911
Place student on his/her side and administer GLUCAGON IMMEDIATELY!

SYMPTOMS OF HIGH BLOOD SUGAR (HYPERGLYCEMIA)
MILD: Frequent urination, Increased Thirst, Blurred Vision, Fatigue, Headache
MODERATE: Abdominal Pain, Dry Mouth, Weakness, Shortness of Breath
SEVERE: Fruity Breath, Confusion, Nausea & Vomiting , Coma

MANAGEMENT OF HIGH BLOOD SUGAR
Notify school nurse and parent
Check blood sugar
Test for ketones and follow doctor's order
Encourage student to drink water or sugar free drinks
Allow free use of restroom
If student becomes unresponsive call 911 and initiate CPR

Instructions for Reconstitution: ADMINISTER GLUCAGON 0.5 mg or 1 mg in ARM OR THIGH



Sent Copies To: Teacher: ___Homeroom ___ 1st ___ 2nd ___ 3rd ___4th ___ 5th ___ 6th ___ 7th ___ 8th ___ Clinic ___PE ___Art ___Music ___Cafeteria ___ Bus Driver ___School Nurse Coordinator/Supervisor ___Library ___Coach/PE ___Computer Lab ___Other

Student Name _____ **DOB** _____

*** As parent/guardian by signing this Health Care Plan, I authorize designated Sumter County School personnel, Sumter County Health Department School personnel, and any other contracted health care agencies to provide emergency care for my child and/or to share or exchange medical information as necessary to support the education and continuity of care of my child. I also give permission for the Sumter County Schools to share this information with faculty/staff who are directly involved in my child's education.**

Parent Signature _____ **Date** _____

☐ **Obtained via telephone interview with parent** **School Year** _____

_____ _____

Nurse Signature and Date **School Health Tech Signature and Date**

_____ _____

Teacher Signature and Date **Teacher Signature and Date**

_____ _____

Other Faculty/Staff (Specify) and Date **Other Faculty/Staff (specify) and Date**

***YEAR 2 REVIEW: Update to Individual Emergency Action Plan** **School Year** _____

Status determined by:

- ☐ **Person-to-person interview**
- ☐ **Telephone interview**
- ☐ **Update letter**
- ☐ **No changes to current plan**

_____ _____

Parent Signature and Date **Nurse Signature and Date**

_____ _____

Teacher Signature and Date **Other Faculty/Staff (Specify) and Date**

***YEAR 3 REVIEW: Update to Individual Emergency Action Plan** **School Year** _____

Status determined by:

- ☐ **Person-to-person interview**
- ☐ **Telephone interview**
- ☐ **Update letter**
- ☐ **No changes to current plan**

_____ _____

Parent Signature and Date **Nurse Signature and Date**

_____ _____

Teacher Signature and Date **Other Faculty/Staff (Specify) and Date**

***Note: 1. Significant changes to the plan of care requires a new Individual Emergency Action Plan be completed.**

2. At the beginning of the 4th school year based on the initial date of this plan a new EAP will be written.