Madison School District 321

Diabetes **HYPOGLYCEMIA**

↓ (low blood sugar) ↓

Emergency Health Care Plan

School Year:	Student Picture
School:	
Grade:	

STUDENT INFORMATION

Student:		DOB:	
Parent:	Phone:	Email:	
Parent:	Phone:	Email:	
Healthcare Provider:	Phone:	Fax:	
District Nurse: Rachel Moore, RN	Phone: 208-206-0908	Fax: 208-359-3370	

SPECIAL CONSIDERATIONS

Special considerations and precautions (regarding school activities, field trips, sports, etc.):

Causes of Hypoglycemia

Too much insulin	Getting extra, intense, or unplanned physical activity
Missing or delaying meals or snacks	Being ill, particularly with gastrointestinal illness
Not eating enough food (carbohydrates)	Sudden onset - symptoms may progress rapidly

Symptoms - MILD TO MODERATE (please circle student's usual symptoms)

anxious	crying	headache	poor concentratin	sweaty
behavior change	dizzy	irritable	poor coordination	weak
blurry vision	drowsy	pale	shaky	other:_____
confused	hungry	personality change	slurred speech	

Treat for hypoglycemia if showing any symptoms above, OR if blood glucose is less than _____ mg/dL

Treatment for MILD TO MODERATE Hypoglycemia

When in doubt, ALWAYS treat for hypoglycemia

1. Provide quick-acting glucose (sugar) product equal to _____ grams of carbohydrates.
   Examples of 15 grams of carbohydrates are:
   - * 4 glucose tablets
   - * 1 tube of glucose gel
   - * 4 ounces of fruit juice
   - * 4-6 ounces (1/2 can) of soda (not diet or reduced sugar)
   - * 0.9 oz pkg of fruit snacks
2. Recheck blood glucose in 15 minutes and repeat treatment if symptoms persist or if blood glucose level is less than _____ mg/dL.
3. Contact student's parents/guardians and District Nurse.
4. Additional treatment: _____

Testing supplies, snacks, and insulin are located:_____

The student should **NEVER** be left alone. Always have an **adult** accompany the student when they are experiencing hypoglycemia.

Symptoms for SEVERE Hypoglycemia (please circle student's usual symptoms)

combative	unable to control airway
unable to swallow	seizure activity or convulsions (jerking movements)
other:_____	unresponsive or unconscious

Treatment for SEVERE Hypoglycemia

1. Position the student on his/her side and **DO NOT** attempt to give anything by mouth!!
3. While treating, instruct another person to **call 911** & parents/guardians
4. Administer emergency medication (glucagon), if prescribed: _____mg injection. Where:_____
5. Stay with student until EMS arrives
6. Notify District Nurse & document on Incident Report Form

Emergency Medication (glucagon) is located:_____

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07/18

PARENT TO COMPLETE

As Parent/Guardian of the named student:

* I give permission for my child's Health Care Provider to release/share information with the District Nurse for the completion of this plan of care and to exchange health information and records.
* I understand the information contained in this plan will be shared with Madison School District staff on a need-to-know basis.
* I give permission to the District Nurse and other Madison School District staff to follow this Emergency Care Plan and administer medication as directed.
* I agree to release, indemnify, and hold harmless the District Nurse and other Madison School District staff from lawsuits, claim expense, demand or action, etc., against them for helping my child with diabetes treatment, provided the personnel are following physician instruction as written in this emergency action plan.
* I understand I am responsible for maintaining necessary supplies, medication, and equipment.
* My child and I understand there are serious consequences for sharing any medication with others.
* I understand I am responsible to notify the District Nurse of any change in my child's health status, care, or medication order. If the prescription on the medication order is changed, I understand a new Medication Request Form, Emergency Care Plan Form, and an amendment to the DMMP must be completed before the school staff can administer the medication.
* I understand that if any emergency medication is administered at school, EMS will be notified for evaluation, monitoring, and possible further treatment.
* I understand that if my child is given emergency medication, he/she may not remain at school unless I can be present to monitor him/her for adverse reactions. I understand that trained school employee volunteers can only monitor him/her until I arrive or EMS arrive.

Parent Name:	**Phone:**
Parent Signature:	**Date:**

HEALTHCARE PROVIDER TO COMPLETE - Please read, check one of the options, and sign below

This student is under my care. This Emergency Action Plan reflects my plan of care.

◯ It is **medically appropriate** for the student to **self-carry and self-administer** diabetes medication *when able and appropriate,* and be in possession of diabetes medication, testing supplies, and snacks at all times. See DMMP.

***** This student has been trained and has demonstrated proper medication administration procedure.***

◯ It is **medically appropriate** for the student to **self-carry** diabetes medication, testing supplies, and snacks, but **NOT to self-administer** medication. Please have the designated school personnel administer this student's medication.

◯ It is **NOT medically appropriate** for the student to **self-carry or self-administer** medication. Please have the designated school personnel maintain the medication, testing supplies, and snacks and administer the medication.

Healthcare Provider Name (print):	**Phone:**
Healthcare Provider Signature:	**Date:**
District Nurse has reviewed this plan:	**Date:**

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