

STUDENT:

DOB:

Emergency Response Plan

MILD LOW BLOOD SUGAR: (Hypoglycemia) - (IF STUDENT IS ALERT)

Student to be treated when blood sugar is below: _____.

Symptoms could include: hunger, irritability, shakiness, sleepiness, sweating, pallor, uncooperative, or other behavior changes.

Additional Symptoms: _____

Treatment of Mild: With any level of low blood sugar **never** leave the student unattended. If treatment is required outside the classroom, **a responsible person should accompany student to the health clinic or office** for further assistance.

Test blood sugar. **If kit is not available**, treat child immediately for low blood sugar.

If blood sugar is between _____ and _____ and lunch is available, escort to lunch and have child eat **immediately!**

If lunch is unavailable, treat immediately as listed below.

If blood sugar is below _____, give _____ oz of juice or (1/3 can) regular sugar pop or _____ glucose tablets.

Retest in 10 minutes. If still below _____ retreat as above.

When blood sugar rises above _____ or when symptoms improve, provide snack or lunch.

Notify parent/guardian and school nurse.

Comments: _____

MODERATE LOW BLOOD SUGAR: (IF STUDENT IS NOT ALERT AND NOT ABLE TO SELF TREAT)

Symptoms: In addition to those listed above for mild low blood sugar, student may be **combative, disoriented or incoherent, slurred speech.**

Treatment for Moderate Low Blood Sugar:

If student is conscious yet unable to self-administer or drink the fluids offered:

Administer 3/4 to 1 tube (3 tsp) of glucose gel, or 3/4 tube to 1 tube of cake decorating gel. **Will need to treat with gel until child is alert!**

Place between cheek and gums and massage, elevate head and encourage student to swallow. Student may be uncooperative.

Notify parent/guardian and school nurse.

Retest in 10 minutes. If still below _____ retreat as above.

Comments: _____

SEVERE LOW BLOOD SUGAR:

Symptoms: **Seizure, loss of consciousness, or unable/unwilling to take gel or juice.**

Stay with student

Roll student on side

Do not put anything in mouth

Appoint someone to call 911

Protect from injury

Contact parent/guardian and school nurse

Give Glucagon subcutaneously (if ordered and if a nurse or other delegated person is available); dose = _____ mg or _____ units

1.0mg= 100 units, 0.5mg=50 units, 0.25mg=25 units, 10 units for < 2yrs.)

mg to be used with intramuscular syringe and units to be used with insulin syringe.

Instructions for mixing glucagon: mix liquid from syringe into vial and draw up the appropriate dose (if child is under the age of 6 years, may use insulin syringe to administer dose).

Comments: _____

HIGH BLOOD SUGAR: Student needs to be treated when blood sugar is above _____.

Call parent or guardian when blood sugar is greater than _____.

Symptoms could include (circle all that apply): extreme thirst, headache, abdominal pain, nausea, increased urination.

Additional symptoms: _____

Treatment for High Blood Sugar:

Student needs to drink increased amounts of fluids and must drink _____ oz. water or DIET pop (caffeine free) every hour (amount of fluid should equal 1oz. per year of age, up to 16oz. max). ✓ Be allowed to carry water bottle. ✓ Be allowed to use restroom as often as needed.

Check urine or blood ketones, if blood sugar is greater than _____ **2x** or when ill/and or vomiting. If urine ketones are **moderate to large** or if blood ketones are greater than 0.6 mmol, **call parent/guardian immediately! Do not allow exercise.**

Administer insulin if ordered and if trained personnel available.

When ketones are moderate-large, recommend child be released from school in order to be treated and monitored more closely by parent/guardian.

If student exhibits nausea, vomiting, stomachache or lethargy, contact parent/guardian, student should be released from school.

Send student back to class if none of the above physical symptoms are present.

Signature

My signature below provides authorization for the above written orders and exchange of health information to assist the school nurse in developing an Individualized Health Plan. I understand that all procedures will be implemented in accordance with state laws and regulations and may be performed by unlicensed designated school personnel under the training and supervision provided by the school nurse. This order is for a maximum of one year.

Physician _____

Date _____

Parent _____

Date _____

School Nurse _____

Date _____

Last revised 6/12/08 by BLB