Diabetes Emergency Action Plan (EAP) York Learning Center

DIABETES EMERGENCY ACTION PLAN (EAP) STUDENT NAME:	School Year:	Picture:

STUDENT INFORMATION			
Student Preferred Name:	DOB:	Grade:	Teacher:
Parent/Guardian:	Phone(s):		Email:
Medical Provider:	Phone:		Fax or email:
School Nurse:	Phone:		Fax or email:

When Blood Glucose is in Target Range (or between _____ and _____)

Student is Usually Fine

HYPOGLYCEMIA – When Blood Glucose is Below 80 (or below _____)

Causes: too much insulin; missing or delaying meals or snacks; not eating enough food; intense or unplanned physical activity; being ill.

Onset: sudden, symptoms may progress rapidly

MILD or MODERATE **HYPOGLYCEMIA**
Please check previous symptoms

- ☐ Anxiety
- ☐ Behavior Change
- ☐ Blurry Vision
- ☐ Confusion
- ☐ Crying
- ☐ Dizziness
- ☐ Drowsiness
- ☐ Hunger
- ☐ Headache
- ☐ Irritability
- ☐ Paleness
- ☐ Personality Change
- ☐ Poor Concentration
- ☐ Poor Coordination
- ☐ Shakiness
- ☐ Slurred Speech
- ☐ Sweating
- ☐ Weakness
- ☐ Other:

SEVERE **HYPOGLYCEMIA**
Please check previous symptoms

- ☐ Combative
- ☐ Inability to Eat or Drink
- ☐ Unconscious
- ☐ Unresponsive
- ☐ Seizures/Convulsions (Jerking)
- ☐ Other:

ACTIONS FOR MILD OR MODERATE **HYPOGLYCEMIA**

Contact School Nurse as soon as symptoms observed. Check blood sugar at side of finger.
WHEN IN DOUBT, Always Treat for Hypoglycemia as Specified Below.

1. Give student fast-acting sugar source (15 grams carbohydrates)
   4 glucose tablets or 1 tube glucose gel
   4 ounces juice or regular soda (not low sugar or sugar free)
   0.9 oz. packet of fruit snacks
2. Wait 15 minutes
3. Recheck blood glucose.
4. Repeat fast-acting sugar source if symptoms persist OR blood glucose is less than 80 or _____
5. Once blood sugar returns to normal, check blood sugar in 1 hour and recommend snack or meal as needed.

Other:

ACTIONS FOR SEVERE **HYPOGLYCEMIA**

1. Don't attempt to give anything by mouth.
2. Position on side, if possible.
3. Contact trained diabetes personnel.
4. Administer glucagon, if prescribed.
5. Call 911. Stay with student until EMS arrives.
6. Contact parents/guardians.
7. Stay with student.

Other:

Never send a student with suspected low blood glucose anywhere alone!!

Continued on next page ----------

Student Name:	DOB:	School Year:

HYPER GLYCEMIA – When Blood Glucose is over 250 (or above _____)

Causes: too little insulin; too much food; insulin pump or infusion set malfunction; decreased physical activity; illness; infection; injury; severe physical or emotional stress.

Onset: over several hours or days.

MILD or MODERATE **HPERGLYCEMIA** Please check previous symptoms		SEVERE **HYPERGLYCEMIA** Please check previous symptoms	
☐ Behavior Changes ☐ Blurry Vision ☐ Fatigue/ Sleepiness ☐ Frequent Urination	☐ Headache ☐ Stomach Pains ☐ Thirst/Dry Mouth ☐ Other:	☐ Blurred Vision ☐ Breathing Changes ☐ (Kussmaul Breathing) ☐ Chest Pain ☐ Decreased Consciousness	☐ Increased Hunger ☐ Nausea/Vomiting ☐ Severe Abdominal Pain ☐ Sweet, Fruity breath ☐ Other:

ACTIONS FOR MILD OR MODERATE **HYPERGLYCEMIA**	ACTIONS FOR SEVERE **HYPERGLYCEMIA**
1. Allow liberal bathroom privileges. 2. Encourage student to drink water or sugar free drinks. 3. Administer correction dose if on a pump 4. Contact Parent/Guardian if blood sugar is over _____mg/dl Other:	1. Administer correction dose of insulin if on a pump 2. Call Parent/Guardian _____ 3. Stay with student 4. Call SRO/911 if Patient has breathing changes or decreased consciousness. Stay with student until EMS arrives. Other:

INSULIN PUMP FAILURE (Please indicate Plan for Insulin Pump Failure)

☐ N/A – not on an Insulin Pump ☐ Parent to Come and Replace Site Student can Replace Site Alone or with Minimal Assistance	☐ Administer Insulin Via Syringe/Vial or Pen ☐ School Nurse Can Replace Site (only if Previously Trained) ☐ Other (Specify):

PARENT/GUARDIAN SIGNATURE

I have read and approve of the above Emergency Action Plan.

Parent:	Signature:	Date:
Emergency Contact:	Relationship:	Phone:

SCHOOL NURSE

Diabetes medication and supplies are Kept: ☐ Student Carries ☐ Backpack ☐ Classroom ☐ Health Room ☐ Other (Specify):

Glucagon Kept: ☐ No Glucagon at School ☐ Student Carries ☐ Backpack ☐ Classroom ☐ Health Room ☐ Other (Specify):

Copies of EAP (this form) distributed to Need to Know Staff: ☐ Classroom Teacher ☐ Transportation ☐ Administration ☐ Other:

School Nurse Signature:	Date: