

## Appendix B Hypoglycemia Emergency Plan

Name of Student: \_\_\_\_\_

School Year: \_\_\_\_\_

Teacher/Home Form: \_\_\_\_\_ Grade: \_\_\_\_\_

Location/description of "fast sugar":  
\_\_\_\_\_

Student Photograph

(It is expected that students have a supply of fast acting sugar at school at all times)

**HYPOGLYCEMIC REACTION:** This student has **Type 1 Diabetes** which is a life-threatening condition if the blood sugar falls too low for the brain to function properly and cause the student to lose consciousness.

### **POSSIBLE SYMPTOMS:**

Sweating, Trembling, Dizziness, Mood Changes, Hunger, Headaches,  
Blurred Vision, Extreme tiredness/paleness

Other, please specify \_\_\_\_\_

Optimum Level (Range) of Blood Sugar is \_\_\_\_\_

### **ACTION-EMERGENCY PLAN: WHEN IN DOUBT TREAT**

> Instruct student to test blood sugar level to confirm symptoms

> If the reading is below 4.0 remain with the student and treat immediately with one of the following:

-6 oz(175 ml) juice/pop (not diet) OR 6 lifesaver candies OR

3 glucose tabs OR 3-4 tsp (10-15 ml) of sugar (3-4 packets) OR

**DO NOT LEAVE STUDENT ALONE**

**CALL PARENTS TO INFORM THEM**

Wait 10-15 minutes, if there is no improvement, repeat the above treatment

If the student is unconscious/unresponsive/seizuring. Do not give food or drink

**\*Roll student on his/her side**

**\*Call 911**

**\*Inform Parents or guardians**

Home Phone #: \_\_\_\_\_

Emergency Contact #: \_\_\_\_\_

I agree that the school may post my child's picture, take the emergency measures and share this information as necessary, with the staff of the school and health care providers.

Date: \_\_\_\_\_ Parent's Signature: \_\_\_\_\_

Personal information is being collected, used and disclosed to school staff and volunteers in accordance with the Personal Health Information Protection Act, Municipal Freedom of Information and Protection of Privacy Act, Education Act ,for the purpose of addressing the student's diabetes