HEALTH RELATED ACTION PLAN
Diabetes Emergency Care for Low Blood Glucose (Hypoglycemia)

Student Name: _______ ID#: _______ School: _______
Emergency Contacts: Parent 1: _______ Phones: _______
Parent 2: _______ Phones: _______

NEVER SEND A CHILD WITH SUSPECTED LOW BLOOD GLUCOSE ANYWHERE ALONE.

Mild Symptoms
- Hunger
- Dizziness
- Irritable
- Shaky
- Weak
- Anxious
- Sleepy
- Headache
- Sweating
- Unable to concentrate
- Other:

Moderate
- Sleepiness
- Erratic Behavior
- Confusion
- Slurred Speech
- Poor Coordination

Severe
- Unable to swallow
- Combative
- Unconscious
- Seizures

ALWAYS Check Blood Glucose ANYTIME the student doesn’t feel well.
If less than ______ begin Action below:
Insert mg/dl

Action for Mild Symptoms
- Provide sugar source
  - 3-4 glucose tabs
  - 4 oz juice
  - 6 oz regular soda, not diet
  - 3 tsp glucose gel
- Wait 10-15 minutes
- Retest blood glucose. If less than ______ mg/dl, repeat sugar source and retest blood in 15 minutes.
- If still less than ______, repeat sugar source and contact parents to pick up.
- If blood glucose is between ______ and ______, student may return to class if feeling well.
- Notify Parent and School Nurse.

Action for Moderate Symptoms
- Provide sugar source
  - 3-4 glucose tabs
  - 4 oz juice
  - 6 oz regular soda, not diet
  - 3 tsp glucose gel
- Wait 10-15 minutes
- Retest blood glucose. If less than ______ mg/dl, repeat sugar source and retest blood in 15 minutes.
- Provide snack if hasn’t had a meal in the last hour.
- After 15 minutes, if still less than ______, repeat sugar source and contact parents to pick up.
- If blood glucose is between ______ and ______, student may return to class if feeling well.
- Notify Parent and School Nurse.

Action for Severe Symptoms
- THIS IS A LIFE THREATENING EVENT
- GIVE GLUCAGON CALL 911
- Position student on side.
- Notify administrator, Parent, School nurse.

School Nurse Signature: ___________________________ Date: ___________________________
Nurse Contact Numbers: ___________________________ ___________________________
Copy given to ___________________________ Date: ___________________________

FUSD Student Health Services
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