*San Francisco Unified School Distirct*
*Student, Family, and Community Support Department*
*School Health Programs*
*1515 Quintara Street*
*San Francisco, CA 94116-1273*
*Tel: 415.242.2615 | Fax: 415.242.2618*

*STUDENT PHOTO*

# DIABETES EMERGENCY CARE PLAN

**For School Use Only**
Location of Medication: _____ Location of Food: _____

**TO BE COMPLETED BY PARENT/CAREGIVER**

Name: _____ Date of Birth: _____ School: _____

Grade:_____ Homeroom Teacher: _____ Room: _____

Parent/Caregiver Name: _____ Phone (home): _____ (cell):_____

Address: _____ Phone (work): _____ Email:_____

**----------TO BE COMPLETED BY THE HEALTH CARE PROVIDER----------**

Health Care Provider Treating Student for Diabetes:_____Ph:_____

| | |
|---|---|
| **SIGNS OF HYPOGLYCEMIA:** Headache, tremors, cold sweat, hunger, irritability, nervousness, pale skin, confusion, drowsiness, weakness or fatigue, dizziness, poor coordination, inability to concentrate, slurred speech, combativeness, uncooperativeness, convulsions, unconscious.<br>**Hypoglycemia: Blood Glucose less than _____**<br><br>**Carbohydrate Source:_____**<br>**Give #gms_____ for Blood Glucose less than_____**<br><br>**Glucagon: IM or SQ Dose:_____**<br><br>**Administer Glucagon when:_____**<br><br>**CALL 911 IF ADMINISTERING GLUCAGON and/or for: _____**<br><br>_____ | **SIGNS OF HYPERGLYCEMIA:** Increased urination, increased thirst, blurred vision, increased hunger, fruity breath, vomiting, stomach pain, weakness, sleepiness, difficulty breathing, coma<br><br>**Hyperglycemia: Blood glucose greater than _____**<br><br>**Treatment for Hyperglycemia: _____**<br><br>_____<br><br>**Student can return to regular activities including PE when: _____**<br><br>**CALL 911 WHEN: _____** |

**Contact parent/caregiver when blood glucose is less than_____or greater than_____**

Notify parents/guardian and document what happened in the First Aid and Medication Logs.
***By law, a completed and signed Medication Form must be on file at the school before medication can be administered at school.**

**I authorize school personnel to implement this Diabetic Emergency Plan as described above.**
**I have completed the medication form(s) FOR EACH medication that might be given at school.**

_____ _____
**Health Care Provider Signature** **Date**

**I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent for school authorities to communicate with the authorized health care provider when necessary.**

_____ _____
**Parent/Caregiver Signature** **Date**