San Francisco Unified School Distirct
Student, Family, and Community Support Department
School Health Programs
1515 Quintara Street
San Francisco, CA 94116-1273
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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.

Hypoglycemia: Blood Glucose less than _____

Carbohydrate Source:_____
Give #gms_____ for Blood Glucose less than_____

Glucagon: IM or SQ Dose:_____

Administer Glucagon when:_____

CALL 911 IF ADMINISTERING GLUCAGON and/or for: _____

_____

SIGNS OF HYPERGLYCEMIA: Increased urination, increased thirst, blurred vision, increased hunger, fruity breath, vomiting, stomach pain, weakness, sleepiness, difficulty breathing, coma

Hyperglycemia: Blood glucose greater than _____

Treatment for Hyperglycemia: _____

_____

Student can return to regular activities including PE when: _____

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**

Doy mi consentimiento para que las autoridades escolares tomen la acción apropiada para la seguridad y bienestar de mi hijo/a. Doy mi consentimiento para que las autoridades escolares se comuniquen con el médico de mi hijo/a, cuando sea necesario.

_____ _____
Firma del padre de familia o encargado Fecha