SAINT AMBROSE
CATHOLIC SCHOOL
923 Pearl Road
Brunswick, OH 44212
330.460.7301

Student Photo

DIABETIC EMERGENCY ACTION PLAN

Student's Name:	**Date of Birth:**
Address:	
Parent/Guardian Name:	**Phone:**
Additional Emergency Contact:	
Glucagon Location:	**Back-Up Location:**

Target Blood Sugar: _____ mg/dl

***** CALL SCHOOL OFFICE AND RN IMMEDIATELY.**

☐ **The student is to attend to his/her Diabetic care and management in accordance with my order during regular school hours and school sponsored activities. He/ she is capable of performing diabetic care task.**

☐ **I DO NOT authorize the student to attend to his/her Diabetic care management.**

Hypoglycemia: Blood sugar < _____

Symptoms:	What To Do:
· Hungry/Shaky · Sweaty/Weak · Irritable/Anxious · Heart racing	¬ If able to swallow, chew 3 glucose tablets OR drink 4 ounces of orange juice (one container). ¬ Recheck blood sugar in 15-20 minutes; needs to be above _____. ¬ If not above _____, repeat with 3 glucose tablets or another 4 ounces of juice. ¬ If no meal or snack within the next hour, then give a 15gm snack.

Severe Hypoglycemia: Blood sugar < 30

Symptoms:	What To Do:
· Confusion · Severe behavior change; may include combativeness · Seizures · Unconsciousness	¬ If unconscious or having a seizure, **CALL 911.** ¬ Glucagon **(give 0.5mg/1mg)** SQ in arm or thigh. OR ¬ If able to swallow, insert ½ tube of Glucose gel or cake decorating gel between cheek and gum.

Hyperglycemia TREATMENT: Blood sugar > _____

Symptoms:	What To Do:
· Extreme thirst · Frequent urination · Nausea/vomiting · Tiredness	¬ Provide water and access to bathroom. ¬ Notify parent of blood sugar results.

Insulin Coverage at Lunch **Insulin Correction**

Carbs	Insulin (Units)	Blood Sugar	Insulin Correction (Units)

I am in agreement with this plan of care and understand it will be shared as needed with members of the school staff to safeguard and promote the health of the student listed above while at school. I will notify the school immediately if: 1) the health status of the student listed above changes, 2) we change physicians, or 3) there is a change or cancellation of the physician's orders.

Parent/Legal Guardian _____ Date _____
Registered Nurse _____ Date _____

MEDICAL REVIEW: I have reviewed the attached Emergency Action Plan (EAP) for _____ AND:

_____ I approve the EAP as written.

_____ I approve the EAP with the attached amendments.

_____ I do not approve of the EAP as written, and substitute orders are attached.

Physician _____ Date _____

☐ Board Office ☐ Bus Garage ☐ Teacher ☐ Other_____