Place Child's Picture Here

Plymouth Public Schools

EMERGENCY HEALTH CARE PLAN DIABETES

STUDENT'S NAME:_____ DOB:_____ GRADE:___

STUDENT ADDRESSS:_____

STUDENT'S BLOOD SUGAR GOAL RANGE: _____

LOW BLOOD GLUCOSE LEVEL (HYPOGLYCEMIA) BLOOD GLUCOSE LEVEL LESS THAN: _____

SYMPTOMS

- Feeling weak or tired
- Shakiness
- Pale complexion
- Hunger
- Blurry vision
- Fast Heartbeat
- Sweating
- Headache
- Stomachache
- Irritability or anxiety
- Dizziness or confusion
- More quiet than usual

STUDENT SPECIFIC SYMPTOMS:

_____
_____
_____

ACTIONS: _____
_____
_____
_____

Note: symptoms of hypoglycemia may change over time. The symptoms that the student reports today may be different in the future.

LOW BLOOD GLUCOSE EMERGENCY (UNCONSCIOUS OR HAVING A SEIZURE)

ACTIONS:

- NEVER attempt to put food or drink into student's mouth if he/she is unconscious or having a seizure
- **CALL** 911
- Call PARENT

(Over)

EMERGENCY HEALTH CARE
PLAN DIABETES (page two)

STUDENT'S NAME:_____

HIGH BLOOD BLUCOSE LEVEL (HYPERGLYCEMIA) BLOOD GLUCOSE ELVEL GREATER THAN: _____

SYMPTOMS

- Deep and rapid breathing
- Fast heartbeat
- Drinking more than usual
- Urinating more than usual
- Nausea and vomiting
- Hunger
- Stomachache
- Feeling tired or sleepy
- Blurry vision
- Dry skin or lips
- Irritability

STUDENT SPECIFIC SYMPTOMS:

_____

_____

_____

ACTIONS: _____

_____

_____

_____

CONTACTS:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Nurse Signature: _____ Date: _____