

Diabetes Emergency Action Plan (EAP)

<b>DIABETES - Emergency Action Plan (EAP)</b> Utah Department of Health & Human Services	School Year:	Picture
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**STUDENT INFORMATION**

Student:	DOB:	Grade:	School:
Parent:	Phone(s):	Email:	
Physician:	Phone:	Fax or email:	
School Nurse:	School Phone:	Fax or email:	

**When Blood Glucose is in Target Range (or between \_\_\_\_\_ and \_\_\_\_\_)**

Student is fine

**HYPOGLYCEMIA** – When Blood Glucose is Below 80 (or below \_\_\_\_\_)

Causes: too much insulin; missing or delaying meals or snacks; not eating enough food; intense or unplanned physical activity; being ill.

Onset: sudden, symptoms may progress rapidly

**MILD OR MODERATE HYPOGLYCEMIA**  
Please check previous symptoms

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anxiety<br><input type="checkbox"/> Behavior change<br><input type="checkbox"/> Blurry Vision<br><input type="checkbox"/> Confusion<br><input type="checkbox"/> Crying<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Drowsiness | <input type="checkbox"/> Hunger<br><input type="checkbox"/> Headache<br><input type="checkbox"/> Irritability<br><input type="checkbox"/> Paleness<br><input type="checkbox"/> Personality change<br><input type="checkbox"/> Poor concentration<br><input type="checkbox"/> Poor coordination | <input type="checkbox"/> Shakiness<br><input type="checkbox"/> Slurred speech<br><input type="checkbox"/> Sweating<br><input type="checkbox"/> Weakness<br><input type="checkbox"/> Other: |
|--|--|--|

**SEVERE HYPOGLYCEMIA**  
Please check previous symptoms

- 
- Combative
- 
- 
- Inability to eat or drink
- 
- 
- Unconscious
- 
- 
- Unresponsive
- 
- 
- Seizures
- 
- 
- Other:

**ACTIONS FOR MILD OR MODERATE HYPOGLYCEMIA**

1. Give student \_\_\_ grams fast-acting sugar source\*
2. Wait 15 minutes.
3. Recheck blood glucose.
4. Repeat fast-acting sugar source if symptoms persist OR blood glucose is less than 80 or \_\_\_\_\_
5. Other:

\*FAST ACTING SUGAR SOURCES (15 grams carbohydrates): 3-4 glucose tablets **OR** 4 ounces juice **OR** 0.9 ounce packet of fruit snacks



**ACTIONS FOR SEVERE HYPOGLYCEMIA**

1. Don't attempt to give anything by mouth.
2. Position on side, if possible.
3. Contact trained diabetes personnel.
4. Administer glucagon, if prescribed.
5. **Call 911.** Stay with student until EMS arrives.
6. Contact parents/guardian.
7. Stay with student.
8. Other:

**Never send a student with suspected low blood glucose anywhere alone!!!**

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Diabetes Emergency Action Plan (EAP)

<b>Student Name:</b>	<b>DOB:</b>	<b>School Year:</b>
<p><b>HYPERGLYCEMIA</b> - When Blood Glucose is over 250 (or above _____)</p> <p><u>Causes:</u> too little insulin; too much food; insulin pump or infusion set malfunction; decreased physical activity; illness; infection; injury; severe physical or emotional stress.</p> <p><u>Onset:</u> over several hours or days.</p>		
 <b>MILD OR MODERATE HYPERGLYCEMIA</b> Please check previous symptoms		 <b>SEVERE HYPERGLYCEMIA</b> Please check previous symptoms
<input type="checkbox"/> Behavior Change <input type="checkbox"/> Blurry Vision <input type="checkbox"/> Fatigue/sleepiness <input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Headache <input type="checkbox"/> Stomach pains <input type="checkbox"/> Thirst/dry mouth <input type="checkbox"/> Other:	<input type="checkbox"/> Blurred vision <input type="checkbox"/> Breathing changes (Kussmaul breathing) <input type="checkbox"/> Chest pain <input type="checkbox"/> Decreased consciousness <input type="checkbox"/> Increased hunger
<b>ACTIONS FOR MILD OR MODERATE HYPERGLYCEMIA</b>		<b>ACTIONS FOR SEVERE HYPERGLYCEMIA</b>
<input type="checkbox"/> Allow liberal bathroom privileges. <input type="checkbox"/> Encourage student to drink water or sugar-free drinks. <input type="checkbox"/> Administer correction dose if on a pump. <input type="checkbox"/> Contact parent if blood sugar is over _____ mg/dl. <input type="checkbox"/> Other:		<input type="checkbox"/> Administer correction dose of insulin if on a pump <input type="checkbox"/> Call parent/guardian. <input type="checkbox"/> Stay with student <input type="checkbox"/> Call 911 if patient has breathing changes or decreased consciousness. Stay with student until EMS arrives <input type="checkbox"/> Other:
<b>INSULIN PUMP FAILURE</b> (please indicate plan for insulin pump failure)		
<input type="checkbox"/> NA/not on an insulin pump <input type="checkbox"/> administer insulin via syringe/vial or pen <input type="checkbox"/> parent to come and replace site <input type="checkbox"/> School nurse can replace site (only if previously trained) <input type="checkbox"/> student can replace site alone or with minimal assistance <input type="checkbox"/> Other (specify):		
<b>PARENT SIGNATURE</b>		
I have read and approve of the above emergency action plan.		
Parent:	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:
<b>SCHOOL NURSE</b>		
Diabetes medication and supplies are kept: <input type="checkbox"/> Student carries <input type="checkbox"/> Backpack <input type="checkbox"/> Classroom <input type="checkbox"/> Health Office <input type="checkbox"/> Front office <input type="checkbox"/> Other (specify):		
Glucagon kept: <input type="checkbox"/> Student carries <input type="checkbox"/> Backpack <input type="checkbox"/> Classroom <input type="checkbox"/> Health Office <input type="checkbox"/> Front office <input type="checkbox"/> Other (specify): <input type="checkbox"/> No Glucagon at school		
<b>Copies of EAP (this form) distributed to 'need to know' staff:</b> <input type="checkbox"/> Classroom Teacher(s) <input type="checkbox"/> Lunchroom <input type="checkbox"/> PE Teacher(s) <input type="checkbox"/> Office staff/administration <input type="checkbox"/> Transportation <input type="checkbox"/> Other (specify):		
<b>School Nurse Signature:</b>		<b>Date:</b>

Addendum: