EMERGENCY CARE PLAN FOR DIABETES
West Fargo Public School

Student_____ **Date**_____**Grade**_____ **DOB**_____

Parent/Guardian_____**Phone**_____(H)_____

_____(C)___________(W)

Does this student ride the bus: Yes No

Preferred Hospital In Case of Emergency_____

Physician Name (Print)_____

Physician Signature_____**Phone**_____

BLOOD SUGAR TESTING

Target Range of blood glucose _____mg/dl to _____mg/dl

Student's self-care blood glucose checking skills:

- ☐ Independently checks own blood sugar
- ☐ May check blood glucose with supervision
- ☐ Requires a school nurse or trained diabetes personnel to check blood glucose
- ☐ Uses a smartphone or other monitoring technology to track blood glucose values

Daily Testing Times at School _____ _____ _____ _____

Method used: Type of meter_____ Test Strip required_____

Testing site: fingertip forearm Other: _____

Testing location: (classroom or nurse office)_____

Testing supplies (kit, sharps container, record) will be stored_____

Continuous glucose monitor (CGM): ☐ Yes ☐ No Brand/model:_____

Alarms set for: Severe Low: _____ Low:_____ High:_____

Predictive alarm: Low: _____ High:_____ Rate of change: Low:_____ High:_____

Threshold suspend setting: _____

Additional information for students with CGM

Confirm CGM results with a blood glucose meter check before taking action on the sensor blood glucose level.

If the student has signs or symptoms of hypoglycemia, check fingertip blood glucose level regardless of the CGM.

Insulin injections should be given at least three inches away from the CGM insertion site.

Do Not disconnect from the CGM for sports activities

If the adhesive is peeling, reinforce it with approved medical tape.

If the CGM becomes dislodged, return everything to the parents/guardians. Do not throw any part away.

Refer to the manufacturer's instructions on how to use the student's device.

Students Self Care CGM Skills	**Independent?**
The student troubleshoots alarms and malfunction	☐ Yes ☐ No
The student knows what to do and is able to deal with a HIGH alarm	☐ Yes ☐ No
The student knows what to do and is able to deal with a LOW alarm	☐ Yes ☐ No
The student can calibrate the CGM	☐ Yes ☐ No
The student knows what to do when the CGM indicates a rapid trending rise or fall in the blood glucose rate.	☐ Yes ☐ No
The student should be escorted to the nurse if the CGM alarm goes off:	☐ Yes ☐ No

Other instructions for the school health team: _____

_____

INSULIN ADMINISTRATION

Physician direction for sliding scale (correction dose) for high blood sugar and/or carbohydrate intake: (To be completed only by the health care provider)

_____

_____

_____

_____

- **Type** of insulin _____
- **Method** of insulin administration (i.e. pen, pump, syringe)_____
- Insulin and supplies will be stored_____
- Will the student need assistance in giving their own insulin? ☐ Yes ☐ No

LOW BLOOD SUGAR (HYPOGLYCEMIA)

Causes Too much insulin in the body
Less food than usual
Increase in exercise, physical activity

Symptoms (Circle all that apply to student)

Sweaty	Shakiness / trembling Dizziness	Hungry	
Irritability	Weak/Poor Coordination	Tired	Headache
Personality change	Inability to concentrate	Other _____	

- **A low blood sugar usually requires immediate care**.
- Many times students will be aware that their blood sugar is low, but this can occur with little warning. The only way to know is to test their blood sugar.
- Frequently a low blood sugar can occur before lunch or after strenuous exercise.
- The student **must be accompanied** to the testing site (i*.e.* nurse office, main office) if not feeling well.
- The student may need a rest period of _____ minutes to recover before participating in activity.

Treatment

I. **Give** the student _____ if their blood sugar is less than _____ and/or is having symptoms of low blood sugar.
2. **Repeat** treatment if symptoms do not improve in 15-20 minutes. Call parent? ☐ Yes ☐ No
3. **Give** a snack of _____ after symptoms subside to prevent recurrence of low blood sugar episode prior to the next meal/snack.
4. Repeat the blood sugar test? ☐ Yes ☐ No
5. **Note:** The student may return to class as soon as he/she is mentally alert and all symptoms have subsided. It may take 20 minutes to recover, however they may not be ready for taking a test or performing at usual ability. Concentration and memory may be compromised.
6. If the student does not respond, is not able to eat or drink, begins to lose consciousness or has a seizure. **CALL 911. If Glucagon is ordered administer NOW**. Also call parents and the school nurse. Never give fluids or solid food as the student could choke on this.
7. **Whenever in doubt CALL 911**

EMERGENCY MEDICATION

This medication requires a written physician's prescription for the school to give. Parent is responsible for keeping track of expiration date on medication and replacing medication before the expiration date.

Glucagon Yes/No (circle one) Medication **IS** required at school (circle one) Yes No

Medication authorization on file (circle one) Yes No

Where is the medication kept: On student Nurse Office Locker Other _____

HIGH BLOOD SUGAR (HYPERGLYCEMIA)

Causes Not enough or forgotten insulin
Too much food / wrong type of food
Illness, infection, stress
Decrease in usual activity

Symptoms (Circle all that apply to student)

Excessive thirst	Stomach ache	Frequent urination
Nausea/vomiting	Blurry Vision	Fruity odor on the breath
Fatigue	Dry Skin	Other_____

- **A high blood sugar does not need urgent care unless the child is ill.**
- It is good for a person to drink plenty of water if their blood sugar is high.
- Sometimes it is hard to know if a child has high or low blood sugar; the only way to know for sure is to test.
- The student may need rest period of _____ minutes to recover before participating in activity.

Treatment

1. **Test** the student's blood sugar. Based on blood sugar reading, the student may require additional insulin according to physician direction.
2. **Provide water** or sugar-free drinks and unrestricted access to restroom.
3. **Call parent** or emergency contact if student has above symptoms.
4. **Call 911** if parent or emergency contact is unavailable and the student is vomiting, lethargic, or too ill to remain at school.

MEALS AND SNACKS

Parent must be notified before student travels outside of the school building so they can plan for this.

Morning snack time_____

Lunch time_____

Afternoon snack time_____

This student will need to be reminded to take his / her snack: ☐ Yes ☐ No

Fast carbohydrate (i.e. juice, glucose tablets, regular soda) should be readily available at all times should low blood sugar symptoms occur. Student's preferred fast-acting food is:

_____ and will be kept_____.

SPORTS

PE teachers and coaches should be familiar with the symptoms and treatment of low blood sugar.

Any activity restrictions? ☐ Yes _____ ☐ No

Regularly scheduled activities (i.e. PE, recess, band, other)

Activity_____ Time_____

Activity_____ Time_____

- Student should **NOT** exercise if blood sugar is below_____ or above _____mg/dl.

NOTE: Parents/guardians and student are responsible for maintaining necessary supplies, snacks, testing kit, medications, and equipment at school.

I give permission to the principal and to the school nurse to share this “Emergency Care Plan” with school faculty and staff as appropriate. This information will be shared for the purpose of providing first aid or other specific emergency care as described in the plan.

I approve of the above “Emergency Care Plan” and request school personnel to follow the above “Emergency Care Plan” in the event of an emergency involving my child. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of this “Emergency Care Plan”. I further agree that the school personnel or nurse may contact the prescriber as needed and that medical information may be shared with school personnel who need to know.

In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the rendering of care in accord with the above “Emergency Care Plan” from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of care in accord with the above “Emergency Care Plan”.

Parent Signature_____ **Date**_____