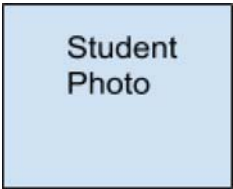




Black River Local Schools

257 A County Road 40  
Sullivan, OH 44880-9731  
www.blackriverschools.org



Elementary – Phone: 419-736-2161 Fax: 419-736-2165  
High School – Phone: 419-736-3303 Fax: 419-736-3302  
Middle School – Phone: 419-736-3304 Fax: 419-736-3309  
Board Office – Phone: 419-736-3300 Fax: 419-736-3308

### DIABETIC EMERGENCY ACTION PLAN

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

**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 < \_\_\_\_\_

<b>Symptoms:</b> <ul style="list-style-type: none"> <li>· Hungry/Shaky</li> <li>· Sweaty/Weak</li> <li>· Irritable/Anxious</li> <li>· Heart racing</li> </ul>	<b>What To Do:</b> <ul style="list-style-type: none"> <li>▢ If able to swallow, chew 3 glucose tablets <u>OR</u> drink 4 ounces of orange juice (one container).</li> <li>▢ Recheck blood sugar in 15-20 minutes; needs to be above _____.</li> <li>▢ If not above _____, repeat with 3 glucose tablets or another 4 ounces of juice.</li> <li>▢ If no meal or snack within the next hour, then give a 15gm snack.</li> </ul>
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**Severe Hypoglycemia: Blood sugar < 30**

<p><u>Symptoms:</u></p> <ul style="list-style-type: none"> <li>· Confusion</li> <li>· Severe behavior change; may include combativeness</li> <li>· Seizures</li> <li>· Unconsciousness</li> </ul>	<p><u>What To Do:</u></p> <ul style="list-style-type: none"> <li>▫ If unconscious or having a seizure, <b>CALL 911.</b></li> <li>▫ Glucagon (<b>give 0.5mg/1mg</b>) SQ in arm or thigh. <span style="margin-left: 100px;"><u>OR</u></span></li> <li>▫ If able to swallow, insert ½ tube of Glucose gel or cake decorating gel between cheek and gum.</li> </ul>
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**Hyperglycemia TREATMENT: Blood sugar > \_\_\_\_\_**

<p><u>Symptoms:</u></p> <ul style="list-style-type: none"> <li>· Extreme thirst</li> <li>· Frequent urination</li> <li>· Nausea/vomiting</li> <li>· Tiredness</li> </ul>	<p><u>What To Do:</u></p> <ul style="list-style-type: none"> <li>▫ Provide water and access to bathroom.</li> <li>▫ Notify parent of blood sugar results.</li> </ul>
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**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 \_\_\_\_\_