


DIABETES - Emergency Action Plan (EAP)
Utah Department of Health

School Year:

Picture

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	 SEVERE HYPOGLYCEMIA Please check previous symptoms
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<input type="checkbox"/> Anxiety <input type="checkbox"/> Behavior change <input type="checkbox"/> Blurry Vision <input type="checkbox"/> Confusion <input type="checkbox"/> Crying <input type="checkbox"/> Dizziness <input type="checkbox"/> Drowsiness	<input type="checkbox"/> Hunger <input type="checkbox"/> Headache <input type="checkbox"/> Irritability <input type="checkbox"/> Paleness <input type="checkbox"/> Personality change <input type="checkbox"/> Poor concentration <input type="checkbox"/> Poor coordination	<input type="checkbox"/> Shakiness <input type="checkbox"/> Slurred speech <input type="checkbox"/> Sweating <input type="checkbox"/> Weakness <input type="checkbox"/> Other:	<input type="checkbox"/> Combative <input type="checkbox"/> Inability to eat or drink <input type="checkbox"/> Unconscious <input type="checkbox"/> Unresponsive <input type="checkbox"/> Seizures <input type="checkbox"/> Other:
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ACTIONS FOR MILD OR MODERATE HYPOGLYCEMIA	ACTIONS FOR SEVERE HYPOGLYCEMIA
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| <ol style="list-style-type: none"> 1. Give student 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: | <ol style="list-style-type: none"> 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: |
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FAST ACTING SUGAR SOURCES (15 grams carbohydrates): 3 4 glucose tablets OR 4 ounces juice OR 0.9 ounce packet of fruit snacks

CONTINUED ON NEXT PAGE

Student Name:	DOB:
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HYPERGLYCEMIA - When Blood Glucose is over 250 (or above _____)

Causes: too little insulin; too much food; insulin pump or infusion set malfunction; decreased physical activity; illness; infection; injury; severe physical or emotional stress.

Onset: over several hours or days.

MILD OR MODERATE HYPERGLYCEMIA Please check previous symptoms	SEVERE HYPERGLYCEMIA Please check previous symptoms
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<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	<input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Severe abdominal pain <input type="checkbox"/> Sweet, fruity breath <input type="checkbox"/> Other:
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ACTIONS FOR MILD OR MODERATE HYPERGLYCEMIA	ACTIONS FOR SEVERE HYPERGLYCEMIA
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<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:
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INSULIN PUMP FAILURE (please indicate plan for insulin pump failure)

<input type="checkbox"/> NA/not on an insulin pump <input type="checkbox"/> parent to come and replace site <input type="checkbox"/> student can replace site alone or with minimal assistance	<input type="checkbox"/> administer insulin via syringe/vial or pen <input type="checkbox"/> School nurse can replace site (only if previously trained) <input type="checkbox"/> Other (specify):
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Never send a child with suspected low blood glucose anywhere alone!!!

PARENT SIGNATURE

I have read and approve of the above emergency action plan.

Parent:	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:

SCHOOL NURSE

Diabetes medication and supplies are kept: Student carries Backpack Classroom Health Office Front office Other (specify):

Glucagon kept: Student carries Backpack Classroom Health Office Front office Other (specify): No Glucagon at school

Copies of EAP (this form) distributed to 'need to know' staff: Classroom Teacher(s) Lunchroom PE Teacher(s) Office staff/administration Transportation Other (specify):

School Nurse Signature:	Date:
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Addendum: