1. RECOGNIZE SIGNS OF ALTERED BLOOD SUGAR LEVELS
IF CHILD UNCONSCIOUS
- Activate EMS – 911
- Notify health office
- Administer medications as ordered
- LSN to administer glucagon as ordered
- Notify Primary Emergency Contact
- Stay with child and reassure until ambulance arrives

For any of the following symptoms send child with an escort to the Health Office for observation and treatment:

<table>
<thead>
<tr>
<th>Hypoglycemia/low blood sugar</th>
<th>Hyperglycemia/high blood sugar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shaky/trembling</td>
<td>Increased thirst/urination</td>
</tr>
<tr>
<td>Dizzy</td>
<td>Weakness</td>
</tr>
<tr>
<td>Pale</td>
<td>Abdominal pain</td>
</tr>
<tr>
<td>Irritable</td>
<td>Generalized aches</td>
</tr>
<tr>
<td>Weak/drowsy</td>
<td>Loss of appetite</td>
</tr>
<tr>
<td></td>
<td>Nausea and vomiting</td>
</tr>
<tr>
<td></td>
<td>Heavy/labored breathing</td>
</tr>
</tbody>
</table>

2. TEST BLOOD SUGAR
- Blood sugar below ____ follow: 3. Low Blood Sugar Flow Chart
- Blood sugar over ____ follow: 4. High Blood Sugar Flow Chart
3. LOW BLOOD SUGAR FLOW CHART (HYPOGLYCEMIA)

*Blood Sugar < _____

Administer 1 Carbohydrate Choice

*NOTIFY PARENT FOR:
- Blood sugar < _____ and after treatment is initiated
- Failure to attain normal blood sugar after _____ cycles of treatment

*NOTIFY LSN FOR:
- Blood sugar < _____ after _____ cycles of treatment
- Signs of low blood sugar _____

Retest Blood Sugar in 15 minutes

*Repeat cycle until blood sugar is > _____

4. HIGH BLOOD SUGAR FLOW CHART (HYPERGLYCEMIA)

Blood Sugar > _____

A. Notify parent and Health Office
B. Test for ketones if supplies available
C. Additional insulin as ordered
D. Have student drink 8 oz. Water

Retest and treat per parent/doctor’s orders

In case of serious illness and I cannot be reached I authorize school personnel to contact:

Physician/Clinic: ____________________________

or transport by ambulance to: ____________________________ Hospital

I agree with this emergency care plan for my child. I give permission for this plan to be carried out and shared with pertinent staff during the current school year. A designation of ECP (Emergency Care Plan) will appear in the alert box found within the Skyward emergency tab.

Parent Signature: ____________________________ Date: ______________

LSN Signature: ____________________________ Date: ______________

Note: Per school district policy, signed physician prescription, parent authorization, and medication in the original container are required for any medication administration at school. See medication form K-5 or 6-12.

Insulin: ____________________________ Date received in health office: ______________

Date physician orders received: ______________

Glucagon: ____________________________ Date received in health office: ______________

Date physician orders received: ______________

Diabetic supplies in Health Office: ______________ Date received in health office: ______________