



DIABETES HYPOGLYCEMIA EMERGENCY ACTION PLAN

Student's Name: _____

Classroom Teacher: _____

Parent/Guardian/Emergency Contacts:
 (Prioritize calls, i.e. 1, 2, 3)

Place Student's
 Picture Here

____ Parent _____ (H) 613- _____ (W) 613- _____ (C) 613- _____
 ____ Parent _____ (H) 613- _____ (W) 613- _____ (C) 613- _____
 ____ Other _____ (H) 613- _____ (W) 613- _____ (C) 613- _____
 (Names, please print)

EMERGENCY TREATMENT FOR HYPOGLYCEMIA

Signs and Symptoms:

- Sweating Trembling Dizziness Mood changes
 Hunger Headaches Blurred vision Extreme tiredness/paleness
 Other, please specify: _____

Optimum Level (Range) of Blood Sugar is _____

Location of Sugar Treatment

- With Student Other, please specify: _____

WHEN IN DOUBT – TREAT

Select one treatment, provided by parent, from the following:

- 6 oz. (125 ml) of fruit juice/drink (junior juice box) **OR**
 3 – 4 tsp. (10 – 15 ml) of sugar (3 – 4 packets) **OR**
 6 oz. (125 ml) of regular pop (not diet type) **OR**
 3 – 4 tsp. (10 – 15 ml) of honey **OR**
 4 – 5 glucose tablets Other _____

CALL PARENTS TO INFORM THEM

Wait 10 – 15 minutes. If there is no improvement, repeat the above treatment.

DO NOT LEAVE THE STUDENT ALONE!

**If the student is unconscious,
 having a seizure or unable to swallow
 DO NOT give food or drink**

- *Roll the student on his/her side**
- *Call 9-1-1**
- *Inform parents/guardians**

Rte #	AM	PM
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Original – School; Copy – Renfrew County Joint Transportation Consortium

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