Diabetes Emergency Action Plan (EAP)
Mumford ISD

This plan should be completed by the student's personal diabetes health care team, including the parents/guardians. It should be reviewed with relevant school staff and copies should be kept in a place that can be accessed easily by the school nurse, trained diabetes personnel, and other authorized personnel.

Date of plan: _____ This plan is valid for the current school year: _____–_____

Student information

Student's name: _____ Date of birth: _____
Date of diabetes diagnosis: _____ □Type 1 □Type 2 □Other: _____

School: _____ School phone number: _____
Grade: _____ Homeroom teacher: _____
School nurse: _____ Phone: _____

Contact information

Parent/guardian 1: _____
Address: _____
Telephone: Home: _____ Work: _____ Cell: _____
Email address: _____

Parent/guardian 2: _____
Address: _____
Telephone: Home: _____ Work: _____ Cell: _____
Email address: _____

Student's physician/health care provider: _____
Address: _____
Telephone: _____ Emergency number: _____
Email address: _____

Other Emergency contacts:
Name: _____ Relationship: _____
Telephone: Home: _____ Work: _____ Cell: _____

Checking Blood Glucose

Target Range of blood glucose: *Before meals*: □ _____-_____ □ Other _____-_____

Check blood glucose level at School:
□ Before breakfast □ After breakfast □ _____Hours after breakfast □ Mid-morning
□ Before lunch □ After Lunch □ ____ Hours after lunch □ Mid-afternoon
□ Before dismissal □ As needed for signs/symptoms of low or high blood glucose

Student's self-care blood glucose checking skills
□ Independently checks own blood glucose
□ 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

Continuous glucose monitor (CGM) □ Yes □ No Brand/Modell: _____
Alarms set for: Severe Low: _____ Low: _____ High: _____
Predictive alarm: Low: _____ High: _____
Rate of Change: Low: _____ High: _____
Threshold suspend setting: _____

- 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.

Student's Self-care CGM Skills	**Independent?**
• The student troubleshoots alarms and malfunctions.	□ 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 level.	□ 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: _____
_____

Hypoglycemia treatment

Student's usual symptoms of hypoglycemia (list below): _____
_____

□ If exhibiting symptoms of hypoglycemia, OR if blood glucose level is less than _____ mg/dL, give a *fast-acting* glucose product equal to _____ grams of carbohydrate.

*FAST ACTING SUGAR SOURCES (15 grams carbohydrates): 3-4 glucose tablets OR 4 ounces juice OR 0.9-ounce packet of fruit snacks

□ Recheck blood glucose in 15 minutes and repeat treatment if blood glucose level is less than _____ mg/dL.

□ Additional treatment: _____
_____

If the student is unable to eat or drink, is unconscious or unresponsive, or is having seizure activity or convulsions

(jerking movement):

□ Don't attempt to give anything by mouth.
□ Position on side, if possible.
□ Contact trained diabetes personnel.
□ Administer glucagon, if prescribed.
□ Call 911. Stay with student until EMS arrives.
□ Contact parents/guardian.
□ Stay with student.
□ Other:_____

Hyperglycemia treatment

Student's usual symptoms of hyperglycemia (list below): _____

_____

□ Check □ Urine □ Blood for ketones every ____ hours when blood glucose levels are above _____ mg/dL.

□ For blood glucose greater than _____ mg/dL AND at least ____ hours since last insulin dose, give correction dose of insulin (see correction dose orders).

□ Notify parents/guardians if blood glucose is over _____ mg/dL.

□ For insulin pump users: see Additional Information for Student with Insulin Pump.

□ Allow unrestricted access to the bathroom.

□ Give extra water and/or non-sugar-containing drinks (not fruit juices): _____ ounces per hour.

□ Additional treatment for Hyperglycemia: _____

□ If the student has symptoms of a hyperglycemia emergency, call 911 (Emergency Medical Services) and contact the student's parents/guardians and health care provider. Symptoms of a hyperglycemia emergency include: dry mouth, extreme thirst, nausea and vomiting, severe abdominal pain, heavy breathing or shortness of breath, chest pain, increasing sleepiness or lethargy, or depressed level of consciousness.

Signatures

This Diabetes Emergency Action Plan has been approved by:

_____

Student's Physician/Health Care Provider Date

I, (parent/guardian) _____, give permission to the school nurse or another qualified health care professional or trained diabetes personnel of (school) _____ to perform and carry out the diabetes care tasks as outlined in (student) _____ Diabetes Emergency Action. I also consent to the release of the information contained in this Diabetes Emergency Action Plan to all school staff members and other adults who have responsibility for my child and who may need to know this information to maintain my child's health and safety. I also give permission to the school nurse or another qualified health care professional to contact my child's physician/health care provider.

Acknowledged and received by:

_____

Student's Parent/Guardian Date

_____

Student's Parent/Guardian Date

_____

School Nurse/Other Qualified Health Care Personnel Date