

DIABETES EMERGENCY ACTION PLAN (EAP)
Utah Department of Health



Nursing & Health Services
Phone: 435-752-3925
Fax: 435-792-7796

**ATTACH
STUDENT
PHOTO**

STUDENT INFORMATION

Student:	DOB:	School:	Grade:	Year:
Parent:	Phone:	Email:		
Physician:	Phone:	Fax:		
School Nurse:	Phone:	Email:		

PHYSICIAN TO COMPLETE

Student is fine when Blood Glucose is in Target Range. **Target range** is _____ to _____.

HYPOGLYCEMIA: When blood glucose is below **80 OR** _____.

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

- | | | |
|---|---|---|
| <input type="checkbox"/> anxiety | <input type="checkbox"/> hunger | <input type="checkbox"/> shakiness |
| <input type="checkbox"/> behavior changes | <input type="checkbox"/> headache | <input type="checkbox"/> slurred speech |
| <input type="checkbox"/> blurry vision | <input type="checkbox"/> irritability | <input type="checkbox"/> sweating |
| <input type="checkbox"/> confusion | <input type="checkbox"/> paleness | <input type="checkbox"/> weakness |
| <input type="checkbox"/> crying | <input type="checkbox"/> personality change | <input type="checkbox"/> other: |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> poor concentration | |
| <input type="checkbox"/> drowsiness | <input type="checkbox"/> poor coordination | |

SEVERE HYPOGLYCEMIA

Please check **PREVIOUS** symptoms

- combative
- inability to eat or drink
- unconscious
- unresponsive
- seizures
- other:

ACTIONS FOR MILD OR MODERATE HYPOGLYCEMIA

1. Give student 15 grams of fast acting sugar source.
2. Wait 15 minutes.
3. Recheck blood glucose. If student has a CGM and they are not within their target range listed on the DMMO, recheck blood glucose using a finger stick.
4. Repeat fast acting sugar source if symptoms persist **OR** blood glucose is less than **80**.
5. Notify parent/guardian if student requires second treatment of 15 grams of carbohydrates.

ACTIONS FOR SEVERE HYPOGLYCEMIA

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:
 - IM Injectable Glucagon 1.0mg/1.0 mL
 - Nasal (Baqsimi) 3 mg
 - SQ Auto injector (Gvoke) 0.5 mg
 - SQ Auto injector (Gvoke) 1.0 mg
- Glucagon kept:** with student in office
5. **CALL 911!** Stay with student until EMS arrives.
6. Contact parents/guardians.
7. Stay with student.
8. Other:

**NEVER SEND A STUDENT WITH SUSPECTED
LOW BLOOD SUGAR ANYWHERE ALONE!!!!**

Student Name:	DOB:	Year:
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HYPERGLYCEMIA: When blood glucose is over 250 OR _____.

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

Onset: over several hours or days.

<p style="text-align: center;">MILD OR MODERATE HYPERGLYCEMIA Please check PREVIOUS symptoms</p>	<p style="text-align: center;">SEVERE HYPERGLYCEMIA Please check PREVIOUS symptoms</p>
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<input type="checkbox"/> behavior changes <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"/> thirsty <input type="checkbox"/> 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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<p style="text-align: center;">ACTIONS FOR MILD OR MODERATE HYPERGLYCEMIA</p>	<p style="text-align: center;">ACTIONS FOR SEVERE HYPERGLYCEMIA</p>
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<ol style="list-style-type: none"> 1. Allow liberal bathroom privileges 2. Encourage student to drink water or sugar free drinks 3. Administer correction dose if insulin IF on a pump 4. Contact parent if blood sugar is over _____ mg/dl 5. Other: 	<ol style="list-style-type: none"> 1. Administer correction dose of insulin IF on a pump 2. Call parent/guardian 3. Stay with student 4. Call 911 if student has breathing changes or decreased consciousness 5. Stay with student until EMS arrives 6. Other:
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INSULIN PUMP FAILURE

<input type="checkbox"/> student not on 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 may replace site IF previously trained <input type="checkbox"/> Other:
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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:
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Emergency Contact Name:	Relationship:	Phone:
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SCHOOL NURSE

Diabetes medication and supplies are kept: Student Carries Front Office Backpack Classroom
 Other:

Glucagon is kept: Front Office Student Carries Backpack Classroom Other:

This emergency plan is to be distributed via PowerSchool or as needed by **front office** to all "need to know" staff.

School Nurse Signature:	Date:
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ADDITIONAL INFORMATION:

ADDENDUM: