



EMERGENCY ACTION PLAN DIABETES HEALTHCARE

Effective Date: _____

Student's Name: _____ Grade: _____

Address: _____ Home Phone: _____

Parent Information:

Father/Guardian: _____

Phone: Home _____ Work _____ Cell _____

Mother/Guardian: _____

Phone: Home _____ Work _____ Cell _____

Other person to contact in an emergency:

Name: _____

Phone: Home _____ Work _____ Cell _____

Hospital Preferred: _____

Physician(s) or Health Care Provider's Name: _____

Phone: _____

Emergency Items to be Left at School	
Glucose tablets _____	Glucagon _____
Snacks _____	Blood glucose meter _____
Glucose Gel _____	Insulin _____
Syringes _____	Other _____

In the event of a low blood sugar response, the procedure routinely followed at school is: To give some form of sugar or carbohydrate, such as ½ carton of milk, ½ cup fruit juice, or ½ cup non diet soda, followed by crackers with cheese. If the student is unconscious, call 911. Call parents/guardians.

I approve the above emergency healthcare action plan as written: Yes _____ No _____

Please make the following changes to the emergency healthcare plan:

Physician Signature Date

Parent/Guardian Signature Date

I give my permission and authorization for this medication to be administered as prescribed above and for doing so, I hereby release from liability and agree to indemnify any personnel or volunteers of Farber Hebrew Day School for any action or inactions associated with the administration of medication to the above student.

Parent/Legal Guardian Signature: _____

Phone Number: _____ Home _____ Work _____