DIABETES EMERGENCY CARE PLAN
Low Blood Sugar

Student Name: ______________________ Date: ______________

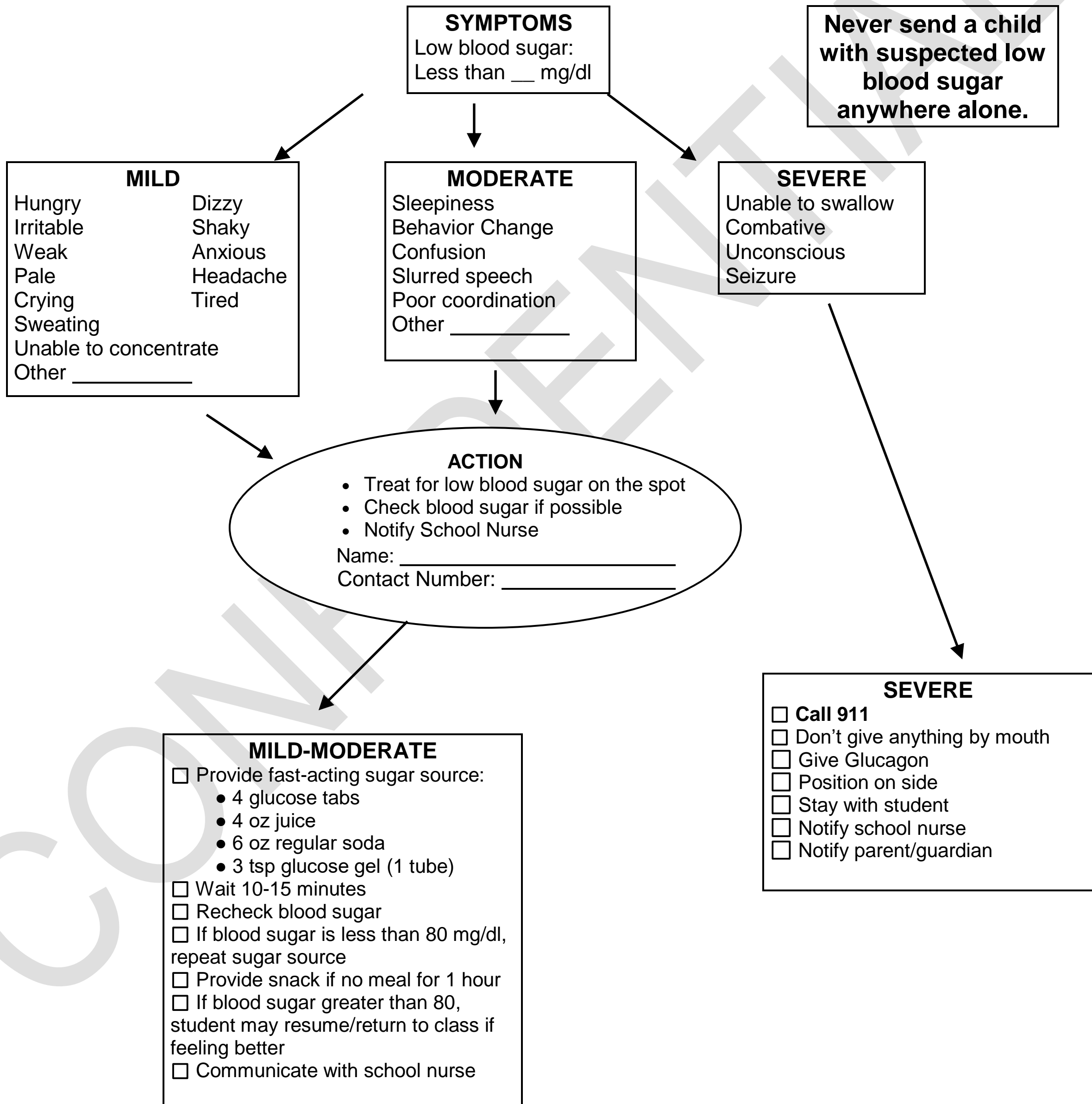
Grade/Teacher: ______________________

School Year/ School: ______________________

Parent/Guardian Name: ______________________ Phone: ______________

Emergency Contact: ______________________ Phone: ______________

Health Care Provider: ______________________ Phone: ______________



CONFIDENTIAL

☐ Additional Instructions: ____

School Nurse
Signature: ______________________ Date: ______________

05/2010

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