## **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:
MILD  Hungry Irritable Shaky Weak Anxious Pale Headache Crying Tired Sweating Unable to concentrate Other  MILD-MODERATE    Provide fast-acting sugar source:	Never send a child with suspected low blood sugar anywhere alone.  SEVERE Unable to swallow Combative Unconscious Seizure
School Nurse Signature:	Date: