To Be Completed by the Health Care Provider

San Francisco Unified School District
School Health Programs Department
1515 Quintara Street
San Francisco, CA 94116-1273
TEL: 415.242.2615
FAX: 415.242.2618

DIABETIC EMERGENCY CARE PLAN

Name: ______________________________ Grade: ______ Age: _____ Date of Birth: _______________

School: ____________________ Homeroom Teacher: ____________________ Room: ______________

Parent/Caregiver Name: ______________________ Phone (home): ______________________________

Address: ______________________________ Phone (work): ________________ (cell)_____________

Attach Student Emergency Card for additional emergency contacts.

Health Care Provider Treating Student for Diabetes:____________________________ Ph: _______________

FOR SIGNS OF HYPOGLYCEMIA: Headache, tremors, cold sweat, hunger, irritability, nervousness, pale skin, confusion, drowsiness, weakness or fatigue, dizziness, tingling lips, poor coordination, inability to concentrate, slurred speech, combativeness, uncooperativeness, convulsions, unconsciousness.

Emergency medications/food:

What to give	Amount	When to give
______________________	___________	______________
______________________	___________	______________
______________________	___________	______________

Location of medication/food: ____

Student can return to the classroom when: ____________________________________

____

CALL 911 WHEN: ____

____

FOR SIGNS OF HYPERGLYCEMIA: Increased urination, increased thirst, blurred vision, increased hunger, fruity breath, vomiting, stomach pain, weakness, sleepiness, difficulty breathing, coma

Instructions for hyperglycemia: ____

Emergency medication:

What to give	Amount	When to give
______________________	___________	______________
______________________	___________	______________
______________________	___________	______________

Location of medication/food: ____

Student can return to the classroom when: ____________________________________

____

CALL 911 WHEN: ____

____

- Contact parent/caregiver

A completed and signed Medication Form must be on file at the school before medication can be administered at school.

I authorize school personnel to implement this Diabetic Emergency Plan as described above.

______________________________________ ______________

Health Care Provider Signature Date

本人同意，爲了本人子女的安全和健康著想，學校當局可採取適當行動。本人同意，必要時，學校當局可與授權的健康護理員聯絡。 ❑ 本人子女不需要服務。

______________________________________ ______________

家長/看顧人簽名 日期