



San Francisco Unified School District  
School Health Programs Department  
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# 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

**Doy mi consentimiento para que las autoridades escolares tomen la acción apropiada para la seguridad y bienestar de mi hijo/a. Doy mi consentimiento para que las autoridades escolares se comuniquen con el médico de mi hijo/a, cuando sea necesario.  Mi hijo/a no necesita los servicios.**

\_\_\_\_\_  
Firma del padre de familia o encargado

\_\_\_\_\_  
Fecha