Whitehall-Coplay School District
Emergency Action Plan (EAP) ~ Diabetes

Student: ___________________________ Date: __________________
Teacher/Classroom: __________ Bus: __________
Diagnosis: ________________________

**Signs of Low Blood Sugar**
(hypoglycemia)
(too little food, too much insulin, too much exercise)

- shaking
- hunger
- irritability

sweating anxious dizziness
blurry vision weakness/fatigue headache
tingling/numbness of lips and tongue

Other known symptoms:

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**Treatment**

1. Give glucose tablet, juice, milk
2. Do not move student; remain with student
3. Notify school nurse/parent
4. If becomes groggy but is still responsive and able to swallow
   * Give 1 tablespoon of glucose gel or frosting in iside the lower lip and massage gently.
5. If unable to swallow and unresponsive:
   * Call 9-911
   * The nurse or trained school personnel will administer:
     Glucagon _________ intramuscularly.
     *(dosage)*
   * Place student on side and remain with student.

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**Signs of High Blood Sugar**
(Hyperglycemia)
(too much food, too little insulin, illness, stress)

extreme thirst frequent urination dry skin drowsiness nausea

**Treatment**

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**Emergency Calls**

1. Parent/guardian:

2. Additional emergency contacts:

3. Physician:

Parent/Guardian Signature: ___________________________ Date: __________
Physician Signature: ___________________________ Date: __________
School Nurse: ___________________________ Date: __________
School personnel informed: ___________________________ Date: __________

Care plans are updated yearly and/or throughout the school year as needed.
WHITEHALL-COPLY SCHOOL DISTRICT

Medication Dispensing Form

To the Physician:

Please complete and sign this form if you request your patient to receive a medication during school hours. By signing this form, you are indicating that the student could not attend school unless this medication was available during the school day.

Medication must be brought in the original bottle and will be kept in the health room. It will be the student’s responsibility to request the medication in the health room.

Student’s name: ___________ Grade: _______ Teacher: ______________

Prescribed medication: ___________________________________________

Dosage*, route, and frequency: ____________________________________

Time of day to be given: _________________________________________

Reason for medication: _________________________________________

Side effects: ___________________________________________________

Is child taking any other medication? Name? ________________________

This authorization is in effect from: ___________ to: ___________ **

☐ Student may carry INHALER / EPIPEN (circle choice) and use as prescribed by licensed provider.

*Licensed Prescriber signature: ____________________ Date: ____________

Print name of Licensed Prescriber: ________________________________

Telephone # of Licensed Prescriber: ________________________________

I do hereby release, discharge, and hold harmless, the Whitehall-Cooply School District, its agents and employees, from any and all liability claim for the administration of the above medication to my child and for any and all injuries resulting there from. I consent for employees of Whitehall-Cooply School District to exchange information regarding this medication with the physician who ordered the medication. Please refer to the school calendar for policies related to medications.

Parent/Guardian signature: ____________________ Date: ____________

*If the dosage is changed at any time, physician must complete new form. Please request additional forms as needed from the school nurse or obtain on-line at www.whitehallcoply.org.

**This form is only valid for school year in which it was completed.
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