

HYPOGLYCEMIA EMERGENCY PROCEDURE INFORMATION

DATE: _____

To the Parent(s)/Guardian(s) of: _____

You have provided our school with information that your child has low blood sugar. In order for school personnel to care for your child effectively, additional information would be helpful. The information you supply will be kept confidential. Please answer the following:

When was your child diagnosed with hypoglycemia? _____

Has your child ever been hospitalized for hypoglycemia? No ___ Yes ___ Date of last hosp. _____

What time(s) does your child receive insulin? _____

How often does your child experience low blood sugar? _____

Which of the following signs and symptoms does your child usually experience **low blood sugar**?

Please circle number:

- | | |
|--|----------------------------|
| 1. Sudden hunger | 8. Visual problem |
| 2. Weakness or lightheadedness | 9. Headache |
| 3. Restlessness or anxiety | 10. Mood change, confusion |
| 4. Pale appearance | 11. Drowsiness |
| 5. Sweating | 12. Cold clammy skin |
| 6. Shakiness, tremors, jittery feeling | 13. Dizziness |
| 7. Rapid strong pulse | 14. Other (specify) |

Please indicate how you would like school personnel to respond to low blood sugar symptoms should the need arise?

1. _____
2. _____
3. _____
4. _____
5. _____

Medication for treatment of low blood sugar: _____

NOTE: Food for treatment of low blood sugar must be supplied by the parent/guardian.

Please return to school nurse as soon as possible. This information will be shared with those with a need to know.

Please note: Medication may not be given without a written doctor's order and a signed parent consent. The information you supply will be handled in a confidential manner. If you have questions, please call me.

Parent/Guardian Signature _____ Date _____