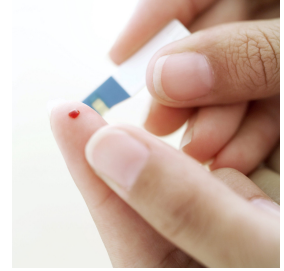




**SYRACUSE CITY SCHOOL DISTRICT  
EMERGENCY CARE PLAN  
DIABETES - HYPERGLYCEMIA**



Student: \_\_\_\_\_ Grade: \_\_\_\_\_ School Contact: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Mother Home #: \_\_\_\_\_ Mother Work #: \_\_\_\_\_ Mother Cell #: \_\_\_\_\_  
 Father: \_\_\_\_\_ FHome #: \_\_\_\_\_ FWork #: \_\_\_\_\_ FCell #: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**SYMPTOMS OF A HYPERGLYCEMIC EPISODE MAY INCLUDE ANY/ALL OF THESE:**

- Gradual Onset
- Extreme thirst, very frequent urination, drowsiness
- Flushed skin, heavy breathing, blurred vision
- Vomiting, fruity or wine-like odor to breath

**SEVERE SYMPTOMS INCLUDE:**

- Stupor
- Unconsciousness

**STAFF MEMBERS INSTRUCTED:**

Administration

Classroom Teacher(s)

Support Staff

Special Area Teacher(s)

Transportation Staff

**TREATMENT:**

Stay with the student.

Notify school nurse immediately.

**Call 911 to access Emergency Medical Services – transport to hospital by ambulance**

Preferred Hospital if transported: \_\_\_\_\_

Notify parents/guardians (do not delay treatment by calling – obtain treatment for student first).

Healthcare Provider: \_\_\_\_\_

Phone: \_\_\_\_\_

Written by: \_\_\_\_\_

Date: \_\_\_\_\_

Copy provided to Parent

Copy sent to Healthcare Provider

**Parent/Guardian Signature** to share this plan with Provider and School Staff: \_\_\_\_\_