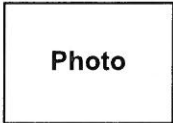


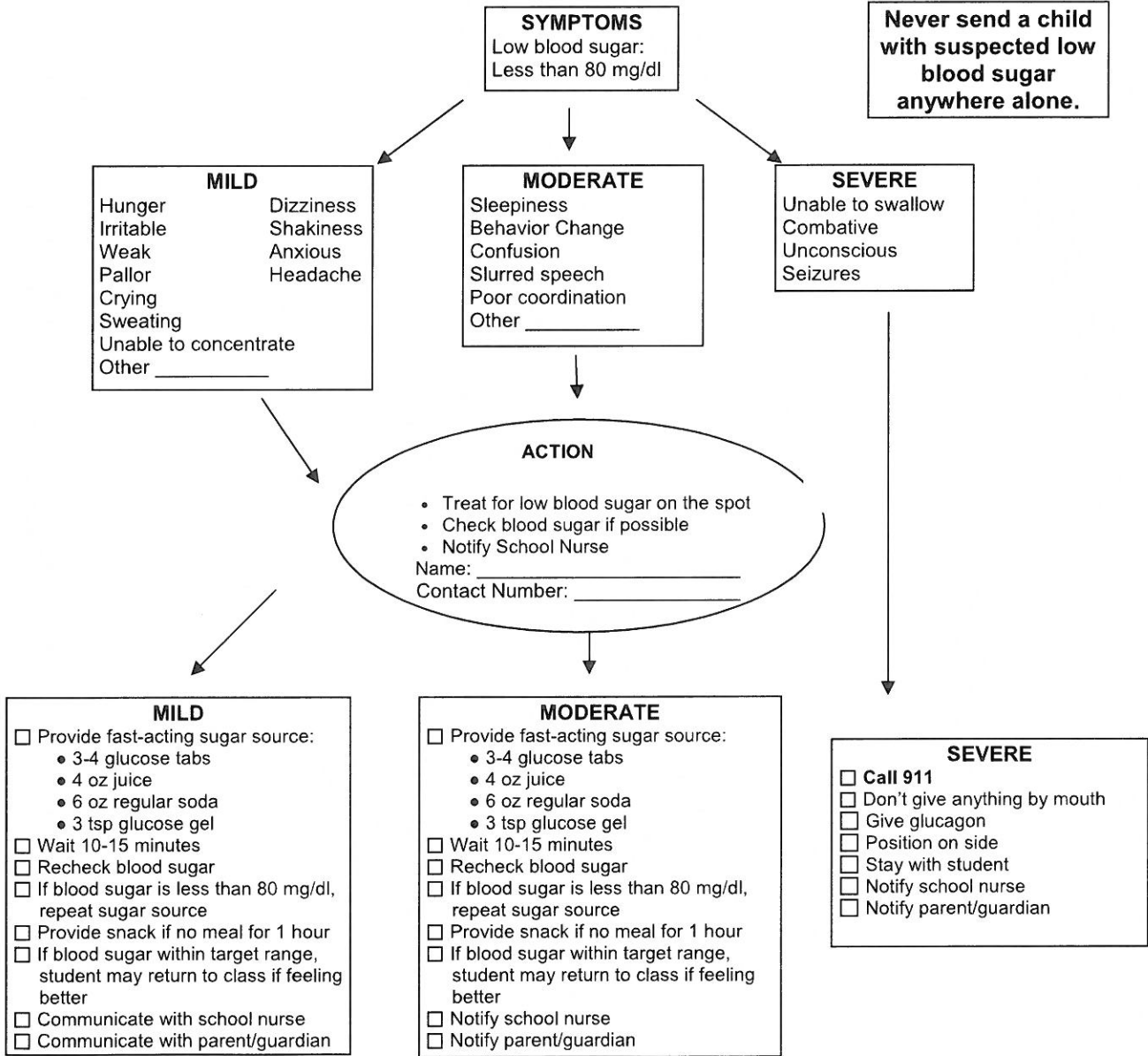
# DIABETES EMERGENCY CARE PLAN

## Low Blood Sugar



**Student Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Grade/Teacher:** \_\_\_\_\_  
**School Year/ School:** \_\_\_\_\_  
**Parent/Guardian:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Health Care Provider:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Never send a child with suspected low blood sugar anywhere alone.**



**School Nurse**  
Signature: \_\_\_\_\_

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