

QUICK REFERENCE EMERGENCY PLAN

Part A of Diabetes Medical Management Plan

HYPOGLYCEMIA

(Low Blood Sugar)

See reverse for Part B and signatures

Student Name

School

Teacher/grade

Mother/Guardian

Father/Guardian

Home phone

Work phone

Cell

Home phone

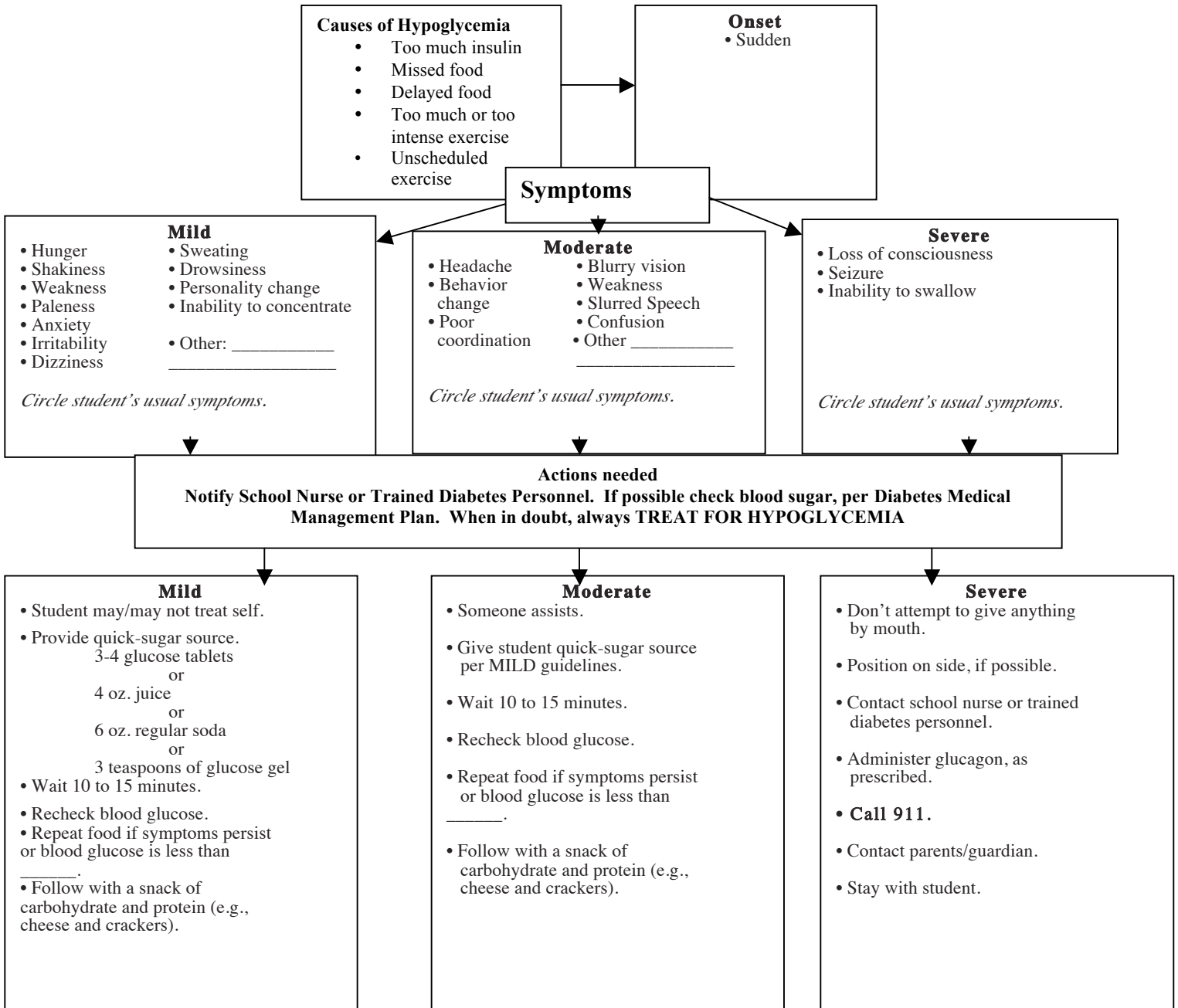
Work phone

Cell

Trained Diabetes Personnel

Contact Number(s)

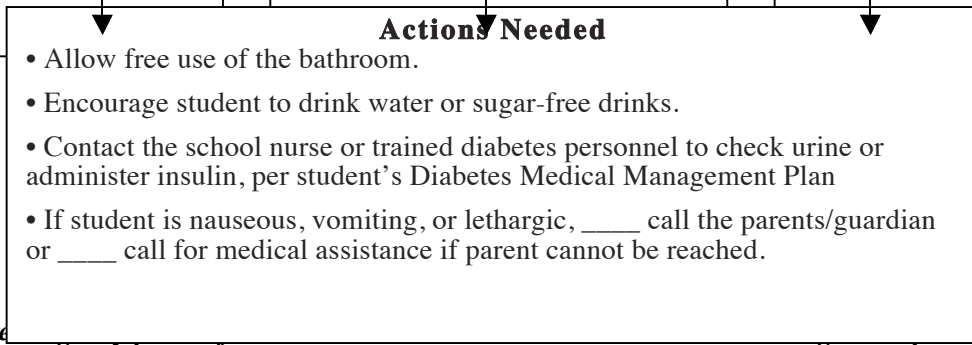
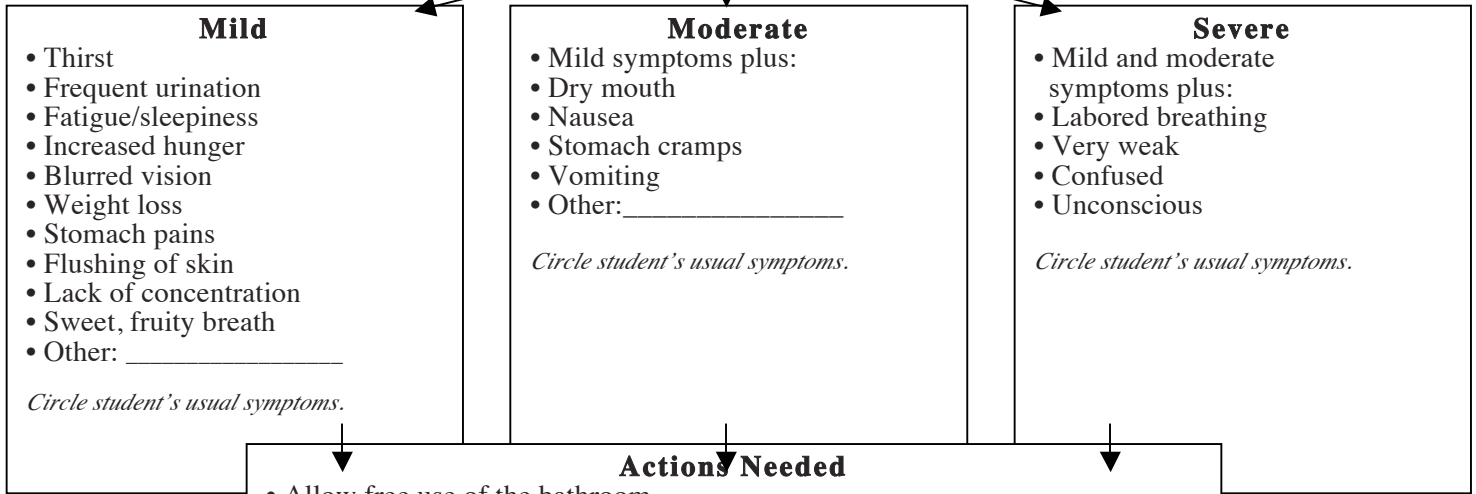
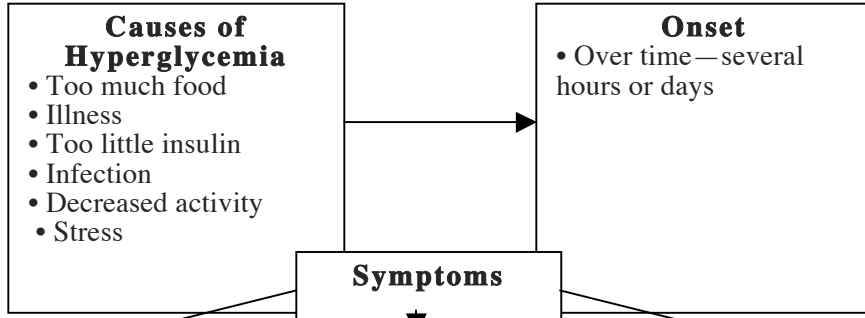
**NEVER SEND A CHILD WITH SUSPECTED LOW BLOOD SUGAR ANYWHERE ALONE.**



**OFFICE OF CATHOLIC SCHOOLS DOCESE OF ARLINGTON**  
**QUICK REFERENCE EMERGENCY PLAN**  
**Part B of Diabetes Medical Management Plan**  
**HYPERGLYCEMIA**  
**(High Blood Sugar)**

Student Name \_\_\_\_\_  
 Teacher/grade \_\_\_\_\_

School \_\_\_\_\_



*This quick reference plan is approved by \_\_\_\_\_ and is authorized by;*

\_\_\_\_\_  
 Licensed Health Care Provider

\_\_\_\_\_  
 Telephone

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Parent

\_\_\_\_\_  
 Telephone

\_\_\_\_\_  
 Date