



**JACKSON R-2 SCHOOL DISTRICT
HYPOGLYCEMIA ACTION PLAN**

Student name _____ Grade _____ Date of Birth _____

Please note that it is vital to your child’s health to maintain a routine eating schedule as well as eating a recommended diet. We ask that you make sure your child eats a good, balanced breakfast, lunch and snack(s) if necessary, in order to keep hypoglycemic reactions to a minimum.

Type of hypoglycemia:

- _____ Fasting; low glucose levels in the morning, before meals, after too much exercise or by fasting
- _____ Reactive; low glucose levels after a meal, normally due to overproduction of insulin in response to sugar intake

Physical Education: class time or hour: _____ Snack before? Yes ___ No ___

Signs of low blood sugar for my child include:

Does child monitor glucose level? Yes _____ No _____ **Implement treatment if blood sugar is \leq** _____

Treatment for Reactive hypoglycemia:

- 1) High protein or carbohydrate snack, avoiding sugar that would stimulate more insulin production
- 2) If severe, a small amount of a sugar snack may be given first, but it **must** be followed by a high protein or carbohydrate snack such as peanut butter or cheese crackers and milk

Treatment for Fasting hypoglycemia:

- 1) Any candy, snack, soda or juice that contains at least 15 grams of sugar
- 2) Monitor student for 15-20 minutes or until recovered

If severe: _____ glucagons tablets **OR** _____ glucagons injection (if available)

If unconscious:

If measures taken to raise blood sugar level have not been successful, we will:

- 1) call 911
- 2) notify parent or emergency contact
- 3) notify physician of record

Emergency items provided by parent and where it can be found:

| | | | |
|-----------------------|-------------------------|-----------------|---------------|
| _____ glucose tablets | _____ in nurse’s office | _____ classroom | _____ bookbag |
| _____ glucagon pen | _____ in nurse’s office | _____ classroom | _____ bookbag |
| _____ glucometer | _____ in nurse’s office | _____ classroom | _____ bookbag |
| _____ snacks | _____ in nurse’s office | _____ classroom | _____ bookbag |
| _____ other _____ | _____ in nurse’s office | _____ classroom | _____ bookbag |

Are there any other instructions that you would like us to follow? _____

Parent/Guardian signature _____ **Date** _____

Person completing form: _____ **Parent** _____ **Physician:** _____