GENEVA COMMUNITY UNIT SCHOOL DISTRICT #304
DEPARTMENT OF NURSING

HYPOGLYCEMIA MANAGEMENT PLAN

CHILD NAME: _____ Grade: _____
School Year: _____
Effective date of plan: _____

According to your child's health records, he/she has been diagnosed with hypoglycemia. To allow us to better care for your child, please provide us with the following information and return it to the school nurse's office.

I. CHILD'S HISTORY

Age of diagnosis: _____
Frequency of reactions: _____
Type of reaction: (check all those that apply)

Symptoms-

- Behaviors or mood changes: (irritability, crying, confusion, inappropriate responses)
- Headache
- Unusually pale, moist, clammy skin
- Tremulous, anxious
- Dizziness
- Blurred vision or vision changes
- Drowsiness, fatigue
- Other symptoms_____

What is the usual time of the day hypoglycemic reactions occur? _____

II. MEDICAL MANAGEMENT

Do snacks need to be eaten at school? _____
At what times will your child need his/her snacks? _____
Does your child have restrictions regarding physical activity? If yes, explain:
_____

III. EMERGENCY INFORMATION

If your child has a hypoglycemic reaction or any difficulty at school, the nurse will institute the following:
1. Medical management as prescribed above
2. Parent or emergency contact will be called if the above mentioned treatment is not effective
3. The child's doctor will be called if parent or emergency contact cannot be reached
4. 911 will be called in severe emergency

IV. EMERGENCY CONTACT INFORMATION:

Name Relationship to Child Phone Numbers
_____
_____

Physician Name_____ Phone Number_____

The hypoglycemia management plan may be shared with school staff to support your child's safety in school. Parents are encouraged to discuss their child's medical needs with the transportation department as well as sponsors/coaches working with your child before or after school hours.

Parent Signature _____ Date _____