



# Diabetic Action Plan

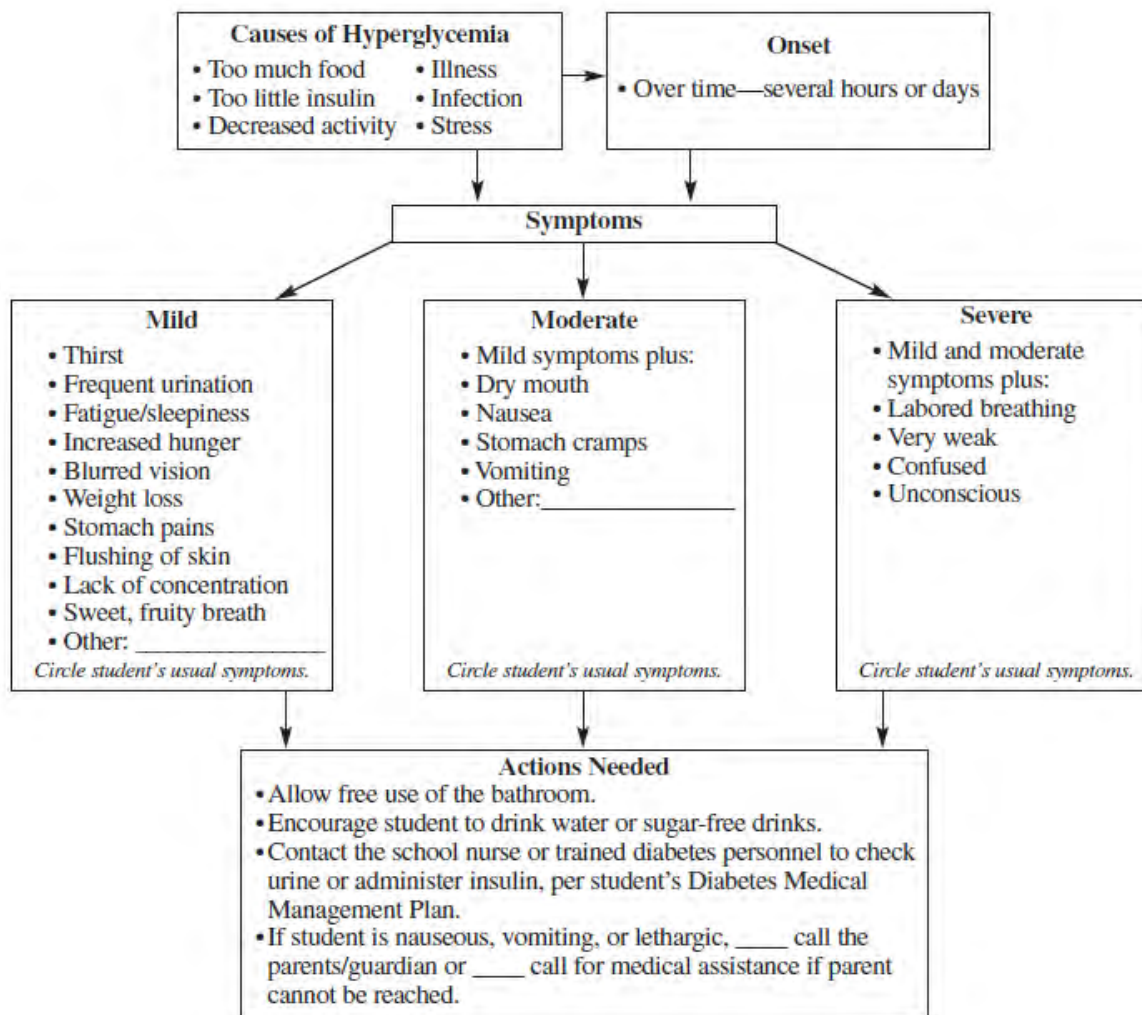
## for a student with Diabetes

### Hyperglycemia

(High Blood Sugar)

School Year \_\_\_\_\_

School:	Grade:	Teacher:
Student's Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name(s):	Work Phone(s):	Cell Phone(s):
Emergency Contact Person:	Contact Phone(s):	
Healthcare Provider Name(s):	Phone:	
School Nurse/Trained Diabetes Personnel	Contact Phone(s):	





# Diabetic Action Plan for a student with Diabetes Hypoglycemia (Low Blood Sugar)

School Year \_\_\_\_\_

School:	Grade:	Teacher:
Student's Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent/Guardian Name(s):	Work Phone(s):	Cell Phone(s):
Emergency Contact Person:	Contact Phone(s):	
Healthcare Provider Name(s):	Phone:	
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