



SAINT CHARLES SCHOOL DISTRICT  
**TRANSPORTATION EMERGENCY ACTION PLAN**

**Diabetes**

Student \_\_\_\_\_ Grade \_\_\_\_\_

Hypoglycemia: Please circle your child's symptoms of hypoglycemia:

Dizziness      hunger      sweating      anxiety      irritability  
weakness      headache      looks pale      other \_\_\_\_\_

Do you want your child's blood sugar tested approximately 20 minutes before boarding the bus? \_\_\_\_\_ Yes      No \_\_\_\_\_

If blood sugar below \_\_\_\_\_, the nurse will give a \_\_\_\_\_ gram carbohydrate snack.

**PLEASE PROVIDE SNACK OR GLUCOSE TABLETS FOR STUDENT TO HAVE ON BUS AT ALL TIMES**

**PROCEDURE OF MANAGING HYPOGLYCEMIA ON THE BUS**

- 1. If student complains of feeling hypoglycemic, eat snack provided by parent**
- 2. Call dispatcher to inform parent and for further instructions.**
- 3. If student becomes unresponsive or has seizure, call 911 for emergency care and transport to hospital**

Contact Numbers:

Mother \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Father \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

If parents cannot be reached:

Contact \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Contact \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

I give permission for this information to be shared as needed with school district personnel

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

**Nothing in this Plan is intended to prevent a call to 911 in the event the school district employee or other district decision makers deem such call to be in the best interest of the child.**

**THIS FORM MUST BE COMPLETED YEARLY**