



DIABETES EMERGENCY HEALTHCARE PLAN (ECP)

Student Name: _____ Date: _____

Birth date: _____ Student ID No. _____ Grade/Room: _____

Parent/Guardian Name: _____ Phone: (____) _____

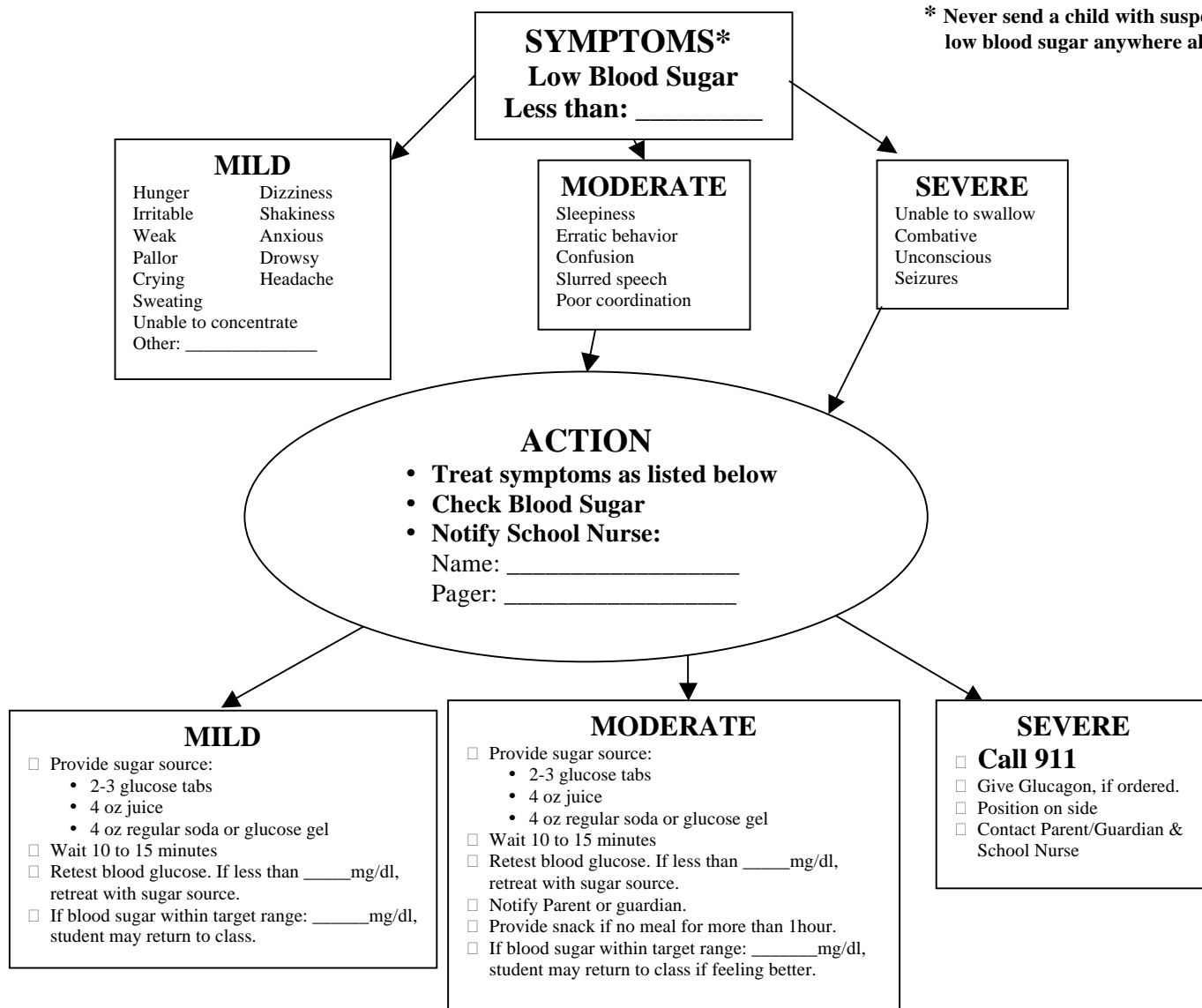
Emergency Contact: _____ Phone: (____) _____

Emergency Contact: _____ Phone: (____) _____

Health Care Provider: _____ Phone: (____) _____

Hospital in case of emergency: _____ Emergency supplies located: _____

*** Never send a child with suspected low blood sugar anywhere alone.**



Licensed School Nurse Signature: _____

Date plan developed: _____

Copy(ies) given to: _____ Date _____

Adapted from P.E.D.S, 200

