

Los Angeles Unified School District
Medical Services Division
Non-Diabetes Hypoglycemia Emergency Care Plan

Student's Name: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female ☐ non-binary

School: _____ **Grade:** _____ **School Year:** _____ **Date of Plan:** _____

| Emergency Contact | Home Phone | Work Phone | Cell Phone |
|--------------------------------|------------|------------|----------------------|
| Mother/Guardian: | | | |
| Father/Guardian: | | | |
| Nurse/Trained school personnel | Title | Work Phone | Other Contact Number |
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