Sacred Heart School

Emergency Health Care Plan: Diabetes (1 of 2)

STUDENT: _____ GRADE: _____

PARENT/GUARDIAN: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

PHYSICIAN: _____ PHONE: _____

BLOOD GLUCOSE:

Usual times to test glucose at school: _____

Extra Tests (check those that apply): ☐ BEFORE EXERCISE ☐ AFTER EXERCISE ☐ OTHER

Can child perform own test? ☐ YES ☐ NO

Adult Supervision ☐ YES ☐ NO

HYPOGLYCEMIA (LOW BLOOD SUGAR):

Usual Symptoms: _____

_____

Usual blood glucose to test for ketones: _____

_____

Treatment: _____

_____

Activity Restriction: _____

_____

HYPERGLYCEMIA (HIGH BLOOD SUGAR):

Usual Symptoms: _____

_____

Usual blood glucose to test for ketones: _____

_____

Treatment: _____

_____

Activity Restriction: _____

_____

Sacred Heart School

Emergency Health Care Plan: Diabetes (2 of 2)

INSULIN

Times: _____

Dose: _____

Method: ☐ Syringe ☐ Pen ☐ Pump

Can student self-administer: ☐ YES ☐ NO

MEALS & SNACKS

Time in School: _____

CIRCUMSTANCES REQUIRING PARENT NOTIFICATION

_____

_____

FIELD TRIPS

A. Received entire IHP

B. Received specific directions for Hyperglycemia and Hypoglycemia

NAME/POSTION	A/B	DATE

Additional necessary accommodations (class trip, testing, busing)

_____

_____

EMERGENCY CARE PLAN

_____

_____

SCHOOL NURSE SIGNATURE	DATE
PARENT/GUARDIAN SIGNATURE	DATE
PARENT/GUARDIAN SIGNATURE	DATE
PHYSICIAN SIGNATURE	DATE
HEALTH CARE TEAM REPRESENTATIVE SIGNATURE	DATE