

Sacred Heart School  
115 Washington Street, Bath, PA 18014  
(610) 837-6391 – Fax (610) 837-2469  
**EMERGENCY HEALTH CARE PLAN: DIABETES**

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ School Year: 2011-12

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Other 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:

\_\_\_\_\_

**INSULIN:**

Time(s): \_\_\_\_\_ Dose: \_\_\_\_\_ Method (Circle) Syringe  
Pen Pump  
Can Student self-administer?  
\_\_\_\_\_

**MEALS AND SNACKS**

Time in School: \_\_\_\_\_  
\_\_\_\_\_

**CIRCUMSTANCES REQUIRING PARENT NOTIFICATION**

**DISTRIBUTION**

- A. Received entire IHP
- B. Received specific directions for Hyperglycemia and Hypoglycemia

<u>NAME/POSITION</u>	<u>A/B</u>	<u>DATE</u>
_____		

Additional necessary accommodations (class trip, testing, busing)

\_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY CARE PLAN:**

\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURES:**

\_\_\_\_\_  
School Nurse

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Health Care Team Representative

\_\_\_\_\_  
Physician