Northampton Area School District

EMERGENCY HEALTH CARE PLAN: **DIABETES**

SCHOOL_____

STUDENT_____GRADE_____DATE_____

Parent/Guardian_____**Phone**_____**Phone**_____

Parent/Guardian_____**Phone**_____**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: _____

What glucose level mandates treatment if no symptoms: _____

Treatment: _____

Glucagon (dose): _____

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

Times in School: _____ _____ _____ _____

CIRCUMSTANCES REQUIRING PARENT NOTIFICATION

_____

_____

_____

DISTRIBUTION

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

NAME/POSITION	A/B	DATE

ADDITIONAL NECESSARY ACCOMMODATIONS
(class trips, testing, bus)

EMERGENCY CARE PLAN

SIGNATURES:

School Nurse

Parent/Guardian

Parent/Guardian

Health Care Team Representative

Physician