

Daily Health Check Addendum for Children with Diabetes

Student: _____ **DOB:** _____ **Today's Date:** _____

Parent/Guardian and student are responsible for providing necessary supplies, snacks, blood glucose meter, medications and other equipment.

Last Blood Glucose/Sensor Glucose: _____ time: _____

¹Last Insulin Brand: _____ dose: _____ time: _____ ²Last Insulin Brand: _____ dose: _____ time: _____

Need	General Supplies for 72 hours:	Notes
<input type="checkbox"/>	Insulin Supply (<input type="checkbox"/> Cartridge, <input type="checkbox"/> Pen, <input type="checkbox"/> Vial)	<input type="checkbox"/> Provided
<input type="checkbox"/>	Insulin Pen/Pen needles	<input type="checkbox"/> Provided
<input type="checkbox"/>	Insulin Syringes	<input type="checkbox"/> Provided
<input type="checkbox"/>	Sharps container	<input type="checkbox"/> Provided
<input type="checkbox"/>	Oral Medication	<input type="checkbox"/> Provided
<input type="checkbox"/>	Blood glucose meter and glucose strips	<input type="checkbox"/> Provided
<input type="checkbox"/>	Lancets with lancing device	<input type="checkbox"/> Provided
<input type="checkbox"/>	Blood ketone monitor/strips	<input type="checkbox"/> Provided
<input type="checkbox"/>	Urine ketone strips	<input type="checkbox"/> Provided
<input type="checkbox"/>	Refillable water bottle	<input type="checkbox"/> Provided
<input type="checkbox"/>	Antibacterial skin cleaner or alcohol wipes	<input type="checkbox"/> Provided
<input type="checkbox"/>	Fast Acting Sugar: (e.g. Glucose tabs, juice, Smarties)	<input type="checkbox"/> Provided
<input type="checkbox"/>	Glucose Gel/Cake Mate	<input type="checkbox"/> Provided
<input type="checkbox"/>	Carbohydrate/Protein snack <input type="checkbox"/> Provided	
<input type="checkbox"/>	Glucagon (<input type="checkbox"/> Lilly/NovoNordisk, <input type="checkbox"/> Gvoke, <input type="checkbox"/> Baqsimi)	<input type="checkbox"/> Provided
<input type="checkbox"/>	Other: _____	
<u>Pump Supplies: Type:</u>		
<input type="checkbox"/>	Insulin Pump	<input type="checkbox"/> Provided
<input type="checkbox"/>	Insulin Pump Batteries	<input type="checkbox"/> Provided
<input type="checkbox"/>	Insulin Pump Cartridge	<input type="checkbox"/> Provided
<input type="checkbox"/>	Pods for OmniPod	<input type="checkbox"/> Provided
<input type="checkbox"/>	Infusion Set	<input type="checkbox"/> Provided
<input type="checkbox"/>	Insertion device	<input type="checkbox"/> Provided
<input type="checkbox"/>	Dressings/tape	<input type="checkbox"/> Provided
<input type="checkbox"/>	Manufacturer Instructions	<input type="checkbox"/> Provided
<input type="checkbox"/>	Batteries	<input type="checkbox"/> Provided
<input type="checkbox"/>	Other: _____	
<u>Continuous Glucose Monitor</u>		
<input type="checkbox"/>	Receiver	<input type="checkbox"/> Provided
<input type="checkbox"/>	Manufacturer Instructions	<input type="checkbox"/> Provided
<u>Supplies Location:</u>		
Location of hypoglycemia supplies: _____		
Location of other supplies & equipment: _____		
<input type="checkbox"/> Student Self Carries/Supplies are kept: _____		
<u>Communication to Parents/Guardians today by:</u> <input type="checkbox"/> Text <input type="checkbox"/> Telephone _____		
<input type="checkbox"/> EMAIL _____		
<u>Notification to be provided by:</u> <input type="checkbox"/> Trained Staff name _____		
<input type="checkbox"/> Programs & Activities Leads name _____		

Parent: _____

Trained Staff: _____