_____ School _____ School Year

AED Checklist

Date	Location	Green Light ✓

Grade: _____ School: _____

School Year: _____

Child Name	Physical Date	Vision/Hearing	BMI/WSC

_____ School _____ School Year

Communicable Disease List

(Separate by Month)

Date of Diagnosis	Type of Communicable Disease

Daily Health Office Visit Log

Date: _____

Time	Student Name	Reason for Visit	Treatment Provided	Resolution (if back to class, state time)	Parent Notified?

Daily Health Office Visit Log

Date: _____

Time	Student Name	Reason for Visit	Treatment Provided	Resolution (if back to class, state time)	Parent Notified?

Student Image Goes Here

Daily Medication

Student: _____ DOB: _____

Grade/Teacher/Room: _____

Medication/Dose/Route/Frequency/Time of Administration/Duration:_____

Date	Time	Dose	RN

RN Signatures: _____ _____

_____ _____

Student Image Goes Here

Daily Medication

Student: _____ DOB: _____

Grade/Teacher/Room:_____

Medication/Dose/Route/Frequency/Time of Administration/Duration:_____
_____

Date	Time	Dose	RN

RN Signatures: _____ _____

_____ _____

School & School Year:

Student Image

Placed Here

Student: _____ **DOB:** _____

Target: _____ **Correction Factor (ISF):** _____ **Insulin to Carb Ratio (ICR):** _____

Date	Time	Blood Sugar	Correction	Carbs	Coverage	Total Units	Notes

School & School Year: _____

Student Name: _____

DOB: _____ Classroom/Grade _____

Student Photo

Goes Here

1. **Insulin to Carb Ratio:**

   # of carbohydrates ÷ _____ = # of units of insulin

   (carb ratio) to cover carbs.

2. **Target _____mG/dL**

   Correction Factor: 1 unit of insulin to _____ mG/dL

   (Blood glucose)_____ − (minus) _____ (target) = X

   X ÷ _____ = # of units of insulin for correction

   (correction factor)

Add Together:

# of units of insulin to cover carbs

+

# of units of insulin correction

=

Total # of units given

_____School _____ School Year

Medications Expiring

Month/Year: _____

Student Name	Medication/s	Date of Expiration

_____ School _____ School Year

Field Trips

Grade	Date of Trip	Where They Are Going	Nurse needed?	If yes, name of RN scheduled

Grade Sheet for Grade _____ **School: _____**

School Year: _____

Name	Physical Date	BMI/WSC	Vision/Hearing V	H	Medical Concerns	Immunization Exemptions

Incoming Kindergarten Grade Sheet **School: _____**

School Year: _____

Name	Physical Date	BMI/WSC	Vision/Hearing V	H	Immunizations missing	Medical Hx	UPK? Or Other

_____School _____ School Year

New Entrant Checklist

Name	DOB	Date Entering	New Entrant Paperwork Submitted?	Physical Date	Immunizations missing or UTD?

_____School _____ School Year

PE Exclusion List

Student	Injury	Date Cleared

_____ School _____ School Year

PE Exclusion List

Student	Injury	Date Cleared

Pill Count Form _____ School Year

Student Name: _____ DOB: _____

Classroom/Grade:_____ Medication: _____

Healthcare Provider: _____ Dosage: _____

Date: _____

Number of Pills Handed Off: _____ Balance: _____

RN Signature: _____

Parent/Guardian Signature: _____

Date: _____

Number of Pills Handed Off: _____ Balance: _____

RN Signature: _____

Parent/Guardian Signature: _____

Date: _____

Number of Pills Handed Off: _____ Balance: _____

RN Signature: _____

Parent/Guardian Signature: _____

Date: _____

Number of Pills Handed Off: _____ Balance: _____

RN Signature: _____

Parent/Guardian Signature: _____

_____School _____ School Year

Student Withdrawals

Student Name	Grade	Date of Withdrawal

Students with Immunization Exemptions

School: _____ School Year: _____

Student Name	Class/Grade	Immunization Exemption

Students with Medical Concerns

School: _____ School Year: _____

Student Name	Class/Grade	Medical Concern