Diabetes Medication Authorization Form

Student Name: _____ Birthdate: _____ Grade/Teacher: _____ School Year: _____

To be completed by physician/licensed prescriber:

	Medication	Dose	Time to be given	Form/Route	Side Effects	Storage
1	Insulin: [ ]Novolog [ ]Apidra [ ]Humalog [ ]Other:_____.		Before Lunch	SQ	Can cause hypoglycemia	Room temperature or refrigerate
2	Glucagon Emergency Kit	[ ] .03 mg. [ ] 0.5 mg. [ ] 1 mg.	PRN for severe low blood sugar	SQ or IM	Can cause vomiting (place on side after administration)	Room temperature

*** Please note that insulin doses change frequently in children. Parents have been instructed in how to make these changes. A physician's order *is not* needed for changes.**

_____ _____ _____

Physician Signature Physician Name Date

To Be Completed By Parent/Guardian:

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of _____'s school to perform and carry out the diabetes care tasks as outlined by _____'s School Plan for a Child with Diabetes. I also consent to the release of the information contained in this School Plan for a Child with Diabetes to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

_____ _____ _____

Parent/Guardian Signature Parent/Guardian Name Date