

I.T.M. Wellness Clinic

Authorization for Carrying/Self Administration of Hypoglycemic Medication

(Use a separate authorization form for each medication)

Student's Name: _____ DOB: _____ Grade: _____

FOR COMPLETION BY PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT:

Physician's Name: _____ Telephone Number: _____

Diagnosis: _____

Name of Medicine, Dosage, and Route of administration _____

Is the child knowledgeable about his/her hypoglycemic medication? Yes No

Has the child verbalized the proper technique in administering medication? Yes No

Medicine is administered when needed. Indications: _____

If needed, how soon can administration of medicine be repeated? _____

The medication cannot be repeated more than _____

Side Effects: _____

_____ I have instructed _____ in the proper way to give his/her hypoglycemic medications. It is my professional opinion that he/she should be **allowed to carry and use** this medication by him/herself, (when conditions allows). **If student's condition renders him/her unable to self administer medication, Do Not Delay Administration of Glucagon During Extreme Hypoglycemic Episodes (Unconsciousness or Seizures).**

_____ It is my professional opinion that _____ should **not be allowed to carry or use** his/her hypoglycemic medication by him/herself.

_____ It is my professional opinion that he/she should be **allowed to carry** their hypoglycemic emergency medication, **but nurse or principal designee must give it.**

Physician Signature: _____ Date _____

FOR COMPLETION BY STUDENT'S PARENT/LEGAL GUARDIAN

Is the child authorized to **carry and self-administer** hypoglycemic medication? Yes No

Is child authorized to **carry medication ONLY**? Yes No

As the parent of the above named student, I ask that assistance be provided to my child at school in taking the medicine (s) indicated above by authorized staff. If self-medicating is allowed and if no authorized staff member is available, I ask that my child be permitted to self-medicate as authorized by myself and his/her physician/healthcare provider. Authorization is hereby granted to release this information to appropriate school personnel and classroom teachers.

Parent/Guardian Printed Name _____ Signature: _____

Contact Phone Numbers: _____ Date: _____