Intermountain® Healthcare

PEDIATRIC DIABETES MEDICATION AUTHORIZATION FORM

ADMINISTRATION OF MEDICATION AND MONITORING AT SCHOOL

Date:_____

Name of child: _____ DOB:_____

Diagnosis: ☐ Type 1 diabetes ☐ Type 2 diabetes

TO BE COMPLETED BY PRESCRIBING HEALTH CARE PROVIDER

MEDICATION

☐ Humalog insulin ☐ Novolog insulin ☐ Apidra insulin

DELIVERY DEVICE

☐ Syringe ☐ Insulin pen

ROUTE

Subcutaneous

DOSAGE

☐ Insulin/Carbohydrate ratio (**before meals and snacks**):_____

☐ Correction insulin dose
(**before meals only** for hyperglycemia): _____

☐ Set dose of insulin:_____

Reportable adverse reactions / side effects:_____

Name of healthcare provider (please print)_____

_____ _____ _____
Healthcare provider signature Phone number Date

SELF-MEDICATION AUTHORIZATION

☐ Capable to carry and self-administer the above medication

☐ Requires supervision to self-administer the above medication

☐ Requires school personnel to administer the above medication

TO BE COMPLETED BY PARENT / GUARDIAN

I hereby give my permission for my child to take medication and do blood glucose monitoring at school as prescribed by my child's prescribing healthcare provider, and I authorize reciprocal release of information related to my child's health/medications between the school nurse and the prescribing healthcare provider.

_____ _____
Signature of Parent / Guardian Date

_____ _____
Work phone number or other daytime phone number Cell phone number or pager number

Medical Authorization Form — back intentionally left blank.

This Medical Authorization Form be torn out to copy and share with school staff.

Patient and Provider Publications 801.442.2963 **IHCEDDB037c – 03/09**