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.

Intermountain Healthcare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Se proveen servicios de interpretación gratis. Hable con un empleado para solicitarlo.

我們將根據您的需求提供免費的口譯服務。請找尋工作人員協助

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Patient and Provider Publications **DB037c-03/09**

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