Alpine Academy of Rockford

Authorization for Administration of Insulin

School Year:_____

Alpine Academy of Rockford requires that both the physician complete this form and parent/guardian before any prescription medication can be given during school hours.

All medication sent to school must be:

1. In the original prescription bottle or container.
2. Properly labeled with the name of the student, the prescribing physician, name of the medication, dosage, route, and the time the medication is to be given.
3. Dropped off in the school office by the parent/guardian.

_____ _____ _____

School Nurse | Phone | Fax

Physician Authorization

Student's Name: _____ DOB: _____

Blood Glucose Monitoring Instructions: _____

Insulin Type: _____

For Lantus:

Insulin/Carbohydrate ratio:_____
Correction Factor:_____

For Pumps:

Type of Pump:_____
Basal Rate:_____
Insulin/Carbohydrate Ratio:_____
Correction Factor:_____

or

Blood Glucose (mg/dl)	**Units**
Below_____	No Insulin
_____ - _____	_____ units
_____ - _____	_____ units
_____ - _____	_____ units
_____ - _____	_____ units
_____ - _____	_____ units
_____ - _____	_____ units
_____ - _____	_____ units

Physician Signature: _____

Physician's Name (Please Print): _____ Phone: _____

Parental Authorization

I authorize Alpine Academy of Rockford and its employees, on my behalf, to administer to my child this lawfully prescribed medication and any prescribed changes. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a registered nurse and specifically consent to such practices. I further acknowledge and agree that when the lawfully prescribed medication is so administration, I waive any claims I might have against the school and its employees arising out of the administration of said medication. In addition, I agree to release, hold harmless, and indemnify the school and its employees from any and all claims, damages, courses of action or injury incurred or resulting from the administration of the said medication.

Parent/Guardian Signature: _____ Date: _____

Phone #1: _____ Phone #2: _____

Revised 11/2007