School District of Clear Lake
Glucagon Administration Authorization Form

Student Name: _____ DOB:_____ Grade:_____ School Year:_____

The student has the skill, knowledge, and authorization to use the medication in the following manner:

____ Student may carry their Glucagon and is responsible for letting a staff member with them know about their diabetes and where their glucagon is located.
____ Student should not carry their personal Glucagon; a staff member will keep medication in primary classroom (Elementary only)
____ Student should not carry their personal Glucagon; it will be kept in the office.

Drug name:	Dosage:	Route:	Special Instructions:
			911 to be called after administration

I hereby give permission for school personnel to administer the medication(s) listed on this sheet to my child according to the practitioner and/or my instructions. I authorize them to contact the practitioner for a question or concern. I further authorize the practitioner to render treatment to my child, as appropriate and necessary, from administering the medication.

Parent/Guardian Name: _____ Phone Number:_____

Signature: _____ Date:_____

Practitioner Information:

Practitioner Name: _____ Clinic: _____

Practitioner Signature:_____Date: _____ Phone: _____

School Nurse Authorization: _____ Date: _____