School Year 2024-2025

Clear Lake School District
Glucagon Administration Authorization Form

Student Name: _____ Grade:_____

School Year:_____ DOB:_____ Grade:_____

- The medication will have the student's name, the name of the medication, directions for use, and an expiration date.
- Authorization forms will be updated annually.

The student has the skill, knowledge, and authorization to use the medication in the following manner:
____ Student may carry their Glugacon.
____ Student should not carry their personal Glucagon; a staff member will keep medication in the 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 with questions or concerns. 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: _____