School Medication Authorization for Students with Diabetes

Student Name: _____

Birthdate: _____ **Grade:** _____ **School Year:** _____

Beaumont Children's Division of Pediatric Endocrinology

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	Medication	Dose	Time to be Given	Form/ Route	Side Effects	Storage
1	**Insulin:** Admelog Apidra Fiasp Humalog/Lispro Novolog/Aspart Other: _____	Flexible ☐ Fixed ☐	Before lunch ☐ Before Breakfast ☐ Before Snack ☐ Other: _____	SQ	Can cause hypoglycemia	Room temperature or refrigerate
2	Glucagon Emergency Kit Baqsimi	0.3mg ☐ 0.5mg ☐ 1mg ☐ 0.3 mg ☐		SQ or IM Nasal	Can cause vomiting; (Roll child onto his/her side after glucagon administration)	Room temperature

*** Please note that insulin doses change frequently in children. Parents have been instructed in how to make these changes. A physician's order *is not* needed for changes.**

Physician Signature _____ Date _____

Physician Name (print) _____

Parent Signature _____ Date _____

Parent Name (print) _____

To Be Completed By Parent/Guardian:

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of_____'s school to perform and carry out the care tasks as outlined by_____'s Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Management Plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.