Constellation Schools

Stockyard Community Elementary and Middle

"The Right Choice for Parents and a Real Chance for Children"

Authorization for Glucometer use in School

Student Name: _____ **Date of Birth:** _____

Address: _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____

School: _____ **Grade:** _____

To be completed by Physician:

My patient, _____ requires the use of a Glucometer to test his/her blood sugar during the school day. The student will perform the test with the assistance of school personnel as needed.

Reason for glucometer use: _____

When should blood sugar be tested? _____

Special instructions: _____

_____

Please list the ranges of blood sugar and the appropriate action to be taken for each range.

Physician's Signature: _____ Date: _____

Physician's Name (printed): _____ Phone: _____

Physician's Address: _____ Zip: _____

I request that my child, _____ be allowed to perform blood sugar testing using a Glucometer in the school setting. My child will perform the test with the assistance of school personnel as needed. Blood sugar testing and actions that need to be taken as a result of the blood sugar levels should be done according to the physician's directions listed above. I will supply the Glucometer. I will supply a new authorization form signed by the physician if any of the above information changes.

Parent/Guardian Signature: _____ Date: _____

Reviewed by School Nurse: _____ Date: _____