



# Constellation Schools

## Westpark Community 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: \_\_\_\_\_