Chestnut Ridge School District
3281 Valley Rd.
Fishertown PA, 15539
(814) 839-4195

Consent Form for Insulin Administration

We request that authorized school personnel administer this prescription medication to _____ (student) _____(grade) according to the directions from our attending physician. As parent/guardian of the above named student, we hereby release the Chestnut Ridge School District and its employees from all liability for damages that our child may suffer as a result of this request.

_____ _____
Date Signature of parent/guardian

****ALL MEDICATION MUST BE BROUGHT TO THE HEALTH ROOM BY A RESPONSIBLE ADULT IN THE ORIGINAL BOTTLE WITH PHARMACY LABEL.**

TO BE COMPLETED BY PRESCRIBING PHYSICIAN

It is essential that the above named student receive the following prescribed medication(s) during school hours:

Type of insulin _____

Mode of delivery (circle): PEN SYRINGE PUMP – (brand)_____

Bolus dose (lunch dose)_____

CORRECTION FACTOR: Coverage schedule for elevated blood sugars:

_____
_____
_____
_____
_____

Other instructions: (**carb to insulin ratio**, diet, tx of hypoglycemia, etc.)

_____
_____

Call physician if: _____

Is student capable of self-administration? _____

_____ _____
Date **Physician signature**

_____ _____
Physician phone and fax number Physician printed name