Saint Thomas Academy

Independent Blood Glucose Monitoring Authorization
(Blood Glucose Testing Outside of the School Health Office)

This form must be completed by a physician and parent/guardian and returned to the school Health Office: Orders must be renewed annually.

School Nurse: ____________________ School: ____________________

Telephone: ____________________ Fax No.: ____________________

To Be Completed By A Physician

I believe that ____________________ is capable of monitoring blood glucose independently.
Student's name

I recommend independent blood glucose monitoring __________ times per day.
Frequency

Comments: ____

Discontinuation date: ____________________

Signature of Physician	Print name	Phone	Date

I hereby give permission for my child to independently monitor blood glucose at school as prescribed by my child's physician and I authorize reciprocal release of information related to medications between the school nurse and the prescribing health professional.

____________________ ____________________

Signature of Parent/Guardian Date