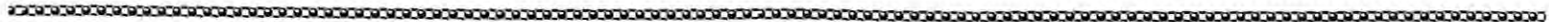




1769 East Moody Blvd. Bldg #2, Bunnell, FL 32110
Phone: 386-517-2060 Fax: 386-517-2052

**AUTHORIZATION TO ADMINISTER PRESCRIPTION MEDICATION TO
STUDENT AND FOR STUDENT TO PERFORM BLOOD GLUCOSE TESTING
ON SCHOOL SITE**



DOCTOR'S AUTHORIZATION (To be completed by doctor)

_____ **BTES** _____
Student's Name School Grade Teacher Date of Birth

The above student is under my medical supervision. I have ordered that blood glucose monitoring be performed

(Number of days per week/ times per day)

Reason for medication to be administered at school: _____

Date this prescription expires: _____

Signature of Doctor: _____ Date _____

_____ **Address Telephone Number**



PARENT / GUARDIAN PERMISSION

I hereby request that my child be allowed to perform blood glucose tasting while on school Site. I have also received and agree to the "Student Blood Glucose Testing Policy"

Signature of Parent/ Guardian: _____ Date: _____

_____ **Parent/ Guardian Name Address**

_____ **Home Phone Number Emergency Phone Number Business Phone Number**



_____ **School Nurse Signature/ Authorized School Personnel Date**