flaglerschools
Engage. Educate. Empower.

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)

Student's Name	School	Grade	Teacher	Date of Birth
	BTES			

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 _____

SCHOOL SCHOULD RETAIN THIS FORM IN THE STUDENTS'S PROFESSIONAL TREATMENT RECORD