



Physician Authorizations and Instructions
For Barat Academy Nurse and Appropriately Trained Staff

Student's Name: _____

DIABETES MELLITUS - The following interventions are ordered:

1. Daily Blood Glucose Checks should be performed (when): _____
2. Daily Medication protocol: _____
3. High Blood Sugar treatment: _____
4. Low Blood Sugar treatment: _____
5. Loss of consciousness: _____
6. Check for ketones: _____
7. Other Instructions: _____

Physician Signature: X _____ Date: _____

ASTHMA

Child's Personal Best Peak Flow Reading is: _____

Green Zone _____ Yellow Zone _____ Red Zone _____

- This student has been trained in the use of _____ MDI and is capable of self-administering the medication. The child has been instructed to notify the school nurse if one dose of medication does not relieve asthma symptoms for at least three hours. This child understands the hazards of sharing medications with others and has agreed to refrain from this practice.
- This student should not carry his/her inhaled medication by him/herself.
- The student should be allowed to carry and use inhaled medication by him/herself.

Physician Signature: X _____ Date: _____

POTENTIALLY LIFE THREATENING ALLERGIES

Student is allergic to _____

If student is having an allergic reaction, the following medications should be administered:

- Epinephrine: _____
(medication / dose / route)
- Antihistamine: _____
(medication / dose / route)
- Other: _____
(medication / dose / route)

Physician Signature: X _____ Date: _____

OTHER MEDICAL PROBLEMS THAT NEED PHYSICIAN INSTRUCTIONS: _____

Physician Signature: X _____ Date: _____

MEDICATIONS AT SCHOOL - *Please complete the reverse side of form (Page 4).*



Barat Academy Authorization for Administration of Medication*
Please Complete Every Item On This Form

Student's Name: _____

PHYSICIAN'S ORDER

I have examined this student for (diagnosis): _____
and have determined he/she requires medication during school hours.

*Barat Academy students may have an Epi-pen, Insulin, Glucagon, or an inhaler in their possession, if the following authorization form is on file in the nurse's office. *PLEASE NOTE: all other medications must be kept in the school office or in the nurse's office.*

- This student should not carry his/her medication by him/herself.
- The student should be allowed to carry and use medication by him/herself.

Name of Medication: _____ Dosage: _____

Name of Medication: _____ Dosage: _____

Directions for Administering Medication: _____

Administration period of above medication(s) (actual dates): From: _____ To: _____

Contact me if the following signs or symptoms appear: _____

Physician Signature: _____ Date: _____

Printed Name: _____ Phone: _____

PARENT/GUARDIAN STATEMENT

I/We, the undersigned parent(s)/guardian(s) of _____
request that the Barat Academy nurse or her designee administer the above named medication to this student according to the
physician's instruction. I/We agree to furnish the necessary prescribed medication in a labeled pharmacy container and agree to notify
the school nurse immediately if the physician or medication prescription is changed. The medication will remain at the school for the
duration of the administration period.

Signature of Parent/Guardian: _____ Date: _____

Home Phone: _____