SCHOOL MEDICATION PERMISSION
FOR ADMINISTRATION OF GLUCAGON
NAPERVILLE COMMUNITY UNIT SCHOOL DISTRICT 203

STUDENT'S NAME: _____ GRADE: _____ BIRTHDATE: _____

ADDRESS: _____ PHONE: _____ SCHOOL: _____

I hereby request that Naperville Community Unit School District 203 employees administer and/or supervise the administration of medication for my child.

I hereby release Naperville Community Unit School District 203 and any of its agents, employees, administrators, volunteers and/or other parties (hereinafter, the "District") from any liability for any injury or harm which is suffered by _____ as a result of our District's agreement to honor this request for administration and supervision of glucagon. I agree to indemnify and hold the District harmless for any legal action or other attempts to acquire compensation, including damages and legal and medical fees, from the District.

_____

PARENT/GUARDIAN SIGNATURE DATE

PHYSICIAN'S AUTHORIZATION AND INFORMATION

DIAGNOSIS: **DIABETES** MEDICATION: **GLUCAGON**

ROUTES OF ADMINISTRATION: **IM/SUBQ** DOSAGE: _____

TIME: IMMEDIATELY IF UNCONSCIOUS AND/OR EXPERENCING SEIZURES

SIDE EFFECTS: _____

DATE OF PRESCRIPTION: _____ DISCONTINUATION DATE: _____

Glucagon may be administered under the following emergency conditions: **UNCONSCIOUS STATE AND/OR SEIZURE**

OTHER MEDICATION STUDENT IS RECEIVING: _____

_____

PHYSICIAN'S SIGNATURE/LICENSED PRESCRIBER'S NAME DATE OFFICE PHONE#

8/02

20-53