ENFIELD PUBLIC SCHOOLS PUPIL PERSONNEL SERVICES

AUTHORIZATION FOR SELF ADMINISTRATION OF INSULIN/INSULIN PUMP

PHYSICIAN'S ORDER:

Date _____

Name of Student _____ Grade _____ Date of Birth _____

Student's Address_____ Home Phone: _____

Condition for which drug is being administered_____

Name of Drug _____ Dose & Frequency_____

Length of time during which medication shall be administered:
School Year _____/_____ or From _____To _____
Date Date
Relevant side effects & management of_____

SELF ADMINISTRATION:

1. I have conferred with this child's parents and feel that this medication may be self-administered.
2. This student has been appropriately instructed regarding self-administration.

_____ _____ _____
Physician's Signature Address Phone

PERMISSION OF PARENT OR GUARDIAN FOR ADMINISTRATION OF MEDICATION

To:_____Date_____

I hereby request that the above medication ordered by

_____
Name of Physician
for_____be self-administered by my child.
Name of Student

I assume responsibility for granting permission for my child to self-administer medication as approved and instructed by the physician.

I understand it would benefit my child for the school nurse to be supplied with back-up medication in the event the medication is lost or misplaced.

I give consent for communication between the nurse and the prescriber to ensure safe administration of the medication.

_____ _____
Signature of Parent/Guardian Telephone

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