Rantoul Township High School Dist. #193

Glucagon Authorization Form

Student name: ______________________________ Birth date: ________________

Address: __________________________________ Phone Number: _________________

Grade: ________________ Date: ________________

To be completed by the child's physician, physician assistant, or advanced practice registered nurse:

Physicians/Health Care Provider's Printed name: ____________________________________

Office Address: ____

Office Phone: ____________________________ Emergency Phone: ________________________

Is it necessary for GLUCAGON to be administered during the school day? ____Yes ____No

Diagnosis of student requiring Glucagon: ____

Dose: ____________________ Frequency: ______________________

Time when Glucagon is to be administered: ___________________________________

Possible expected side effects: ____

Other medication student is receiving: ____

Prescription Date: ______________Order Date: _______________

__________________________________ ____________________________

Physician Signature **Date**

To be completed by the student's parent/guardian:

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Rantoul Township High School and its employees and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer pursuant to State law while under the supervision of the employee and agents of District #193), lawfully prescribed medication in the manner described above. **I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse and specifically consent to such practices,** and I agree to indemnify and hold harmless Rantoul Township High School and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration of the child's self-administration of medication.

Phone: _________________________ Emergency Phone: _______________________

____ ________________________

Parent/Guardian signature Date

5-2015