



University of Iowa Health Care

Pediatric Endocrinology and Diabetes

200 Hawkins Drive 2857 JPP
Iowa City, Iowa 52242
319-356-2838 Tel
319-356-8170 Fax
www.uihealthcare.com/children

AUTHORIZATION FOR PROCEDURE

Name of Student: _____ Date of birth: _____

1. Name/Type of Procedure: **BLOOD GLUCOSE CHECKING**
2. Supplies: PARENTS SHOULD PROVIDE METER, STRIPS, LANCETS AND LANCET DEVICE.
3. Times to be checked: BEFORE MEALS, SUCH AS BEFORE BREAKFAST AND LUNCH EATEN AT SCHOOL.

ALSO MAY CHECK BLOOD SUGAR AT ANY OTHER TIME DEEMED NECESSARY BY THE PARENT(S) SUCH AS BEFORE/AFTER PE, BEFORE ENTERING SCHOOL BUS, BEFORE/AFTER SPORTING EVENTS, ETC...

***** CHECK BLOOD SUGAR IMMEDIATELY ANY TIME STUDENT FEELS A LOW BLOOD SUGAR*****

4. Recording of result: RECORD RESULT ON A LOG SHEET AND COMMUNICATE RESULT TO PARENT(S) DAILY.
5. Duration (week, month, indefinite, etc.) INDEFINITE

Physician Signature

Date

Physician's printed name