



University of Iowa Health Care

Pediatric Endocrinology and Diabetes

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AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

Name of Student: _____ Date of birth: _____

1. Name/Type of medication: **GLUCAGON EMERGENCY KIT**
2. Dosage/Amount to be given: **0.5 MG (HALF DOSE – use when weight under 45 lbs)**
3. Frequency/times to be administered: IF STUDENT IS UNABLE TO SWALLOW JUICE, OR IS HAVING A SEIZURE OR IS UNCONSCIOUS.
4. Administration method: INTRAMUSCULAR INJECTION INTO THIGH MUSCLE
5. Duration (week, month, indefinite, etc.): INDEFINITE
6. Anticipated reaction to medication: INCREASE BLOOD GLUCOSE; STOP SEIZURE; BRING STUDENT OUT OF UNCONSCIOUSNESS. THIS MAY TAKE 5-20 MINUTES TO WORK. *****MAY CAUSE VOMITING*****

THIS MAY BE ADMINISTERED BY ANYONE TRAINED TO ADMINISTER IT.

Physician Signature

Date

Physician's printed name