*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: **1.0 MG (FULL DOSE – use when over 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