



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: GLUCOSE TABLETS
2. Dosage/Amount to be given: 3 SQUARE OR 4 ROUND TABLETS
3. Frequency/times to be administered: FOR BLOOD SUGAR BELOW 70; MAY BE REPEATED EVERY 15 MINUTES IF BLOOD SUGAR REMAINS BELOW 70 ON RECHECK
4. Administration method: ORAL CHEWABLE TABLETS
5. Duration (week, month, indefinite, etc.): AS NEEDED FOR TREATMENT OF LOW BLOOD SUGAR (<70)
6. Anticipated reaction to medication: BLOOD GLUCOSE LEVEL SHOULD RETURN TO NORMAL 15 MINUTES AFTER FINISHING GLUCOSE TABLETS

Physician Signature

Date

Physician's printed name