



University of Iowa
**Children's
Hospital**

Pediatric Endocrinology and Diabetes

University of Iowa Health Care

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AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION

Name of Student: _____ Date of birth: _____

1. Name/Type of medication: **HUMALOG INSULIN**
2. Dosage/Amount to be given: CURRENT DOSE: _____ UNITS, DOSE MAY VARY; PARENTS WILL NOTIFY OF DOSAGE CHANGES.
3. Time: **IMMEDIATELY BEFORE (WITHIN 15 MINUTES) OF EATING LUNCH**
4. Administration method: SUBCUTANEOUS INJECTION VIA SYRINGE OR PEN
5. Duration (week, month, indefinite, etc.): INDEFINITE
6. Anticipated reaction to medication: DECREASE BLOOD GLUCOSE FOLLOWING A MEAL. MAY CAUSE A LOW BLOOD GLUCOSE (<70mg/dl).

THIS MAY BE ADMINISTERED BY ANYONE TRAINED TO ADMINISTER IT.
OMISSION OF INSULIN OR DOSAGE ERROR MAY BE LIFE THREATENING.

CORRECTION FACTOR: Add to lunch injection to correct high blood sugar

If blood sugar between: _____ Add the following units to lunch injection:

Max: _____ units

Physician Signature

Date

Physician's printed name