

**Saint Thomas Academy**  
Independent Blood Glucose Monitoring Authorization  
(Blood Glucose Testing Outside of the School Health Office)

This form must be completed by a physician and parent/guardian and returned to the school Health Office:  
Orders must be renewed annually.

School Nurse: \_\_\_\_\_ School: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax No.: \_\_\_\_\_

To Be Completed By A Physician

I believe that _____ is capable of monitoring blood glucose independently. <span style="margin-left: 100px;"><small>Student's name</small></span>			
I recommend independent blood glucose monitoring _____ times per day. <span style="margin-left: 200px;"><small>Frequency</small></span>			
Comments: _____			
Discontinuation date: _____			
_____ Signature of Physician	_____ Print name	_____ Phone	_____ Date

I hereby give permission for my child to independently monitor blood glucose at school as prescribed by my child's physician and I authorize reciprocal release of information related to medications between the school nurse and the prescribing health professional.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

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