

Date: [Date]

To: [Name of School/Organization/Childcare Provider]

From: [Parent/Guardian Name]

Re: Insulin Medication Administration Authorization for [Student/Child's Full Name]

I, [Parent/Guardian Name], hereby authorize the trained staff at [Name of School/Organization] to administer insulin medication to my child, [Student/Child's Full Name], born on [Date of Birth], as prescribed by their healthcare provider.

**Medication Details:**

- **Insulin Name/Type:** [Name of Insulin, e.g., Humalog, Novolog]
- **Delivery Method:** [e.g., Insulin Pen, Syringe, or Insulin Pump]
- **Dosage Instructions:** [e.g., Fixed dose of X units, or based on Carbohydrate Ratio of 1:X]
- **Administration Times:** [e.g., Before lunch, as needed for high blood sugar, or per sliding scale]

**Healthcare Provider Information:**

Physician Name: [Doctor's Name]

Clinic/Hospital: [Clinic Name]

Phone Number: [Doctor's Phone Number]

In the event of a diabetic emergency (Hypoglycemia/Hyperglycemia), please follow the attached Diabetes Medical Management Plan (DMMP). I understand that it is my responsibility to provide all necessary supplies, including insulin, needles/pens, alcohol swabs, and glucose monitoring equipment, and to ensure they are not expired.

This authorization is valid from [Start Date] to [End Date/End of School Year].

Sincerely,

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Parent/Guardian Signature

[Parent/Guardian Printed Name]

[Phone Number]

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Physician/Healthcare Provider Signature (Required)

[Physician Printed Name]

[Date]