2020-2021 PHYSICIAN AUTHORIZATION FOR GLUCAGON

LEXINGTON CHRISTIAN ACADEMY
450 West Reynolds Road, Lexington KY 40503
(859) 422-5700 * www.lexingtonchristian.org

Lexington Christian Academy has adopted a procedure wherein a member of the staff of the campus the student is attending will administer either an injection or prescribed drug in the event of a crisis. The undersigned understands that the staff member administering the above care is not a trained health professional, but is trained by Andrew Carlson, LCA's Head Athletic Trainer and BLS Certified Instructor, and that this individual will undertake to do his or her best to comply with the recommended procedure as developed by the student's physician in the case of a life-threatening emergency wherein immediate intervention is required by the staff member. The undersigned Parent/Guardian does hereby consent to the intervention of the staff member in accordance with the Physician's instructions. Additionally, the undersigned agrees to hold that staff member harmless for any injuries resulting from the emergency care unless the injury was caused by the staff member's negligence.

PHYSICIAN ORDER FOR GLUCAGON

To be completed by the student's physician and returned to the applicable campus office.

Student's Name: _____ **DOB:** ___ / ___ / ___

Campus: _____ **Grade Level:** _____ **Homeroom Teacher:** _____

Parent/Guardian Name: _____ **Cell #:** _____

Parent/Guardian Name: _____ **Cell #:** _____

ALLERGIES: _____

STUDENT'S TYPICAL REACTION: _____

ACTION TO BE TAKEN:

__ I order the administration of Glucagon for treatment of severe hypoglycemia. I understand that since the school will train a staff member to administer the drug if needed.

Please administer Glucagon/Glucagen 1 mg by IM injection for blood sugar below _____ or unconsciousness. Must follow with a snack and contact Parent/Guardian.

***Will we require notification of Parent/Guardian and/or 911 when Glucagon is administered.**

Physician's Name: _____ **Phone #:** _____

Physician's Signature: _____ **Date:** _____

PARENT/GUARDIAN STATEMENT

▪ I, the undersigned Parent/Guardian of _____, request that a trained staff member to administer the above medication to my student per physician's instructions. I agree to furnish the necessary prescribed medication and agree to notify the school administrator immediately of any changes. I sign this voluntarily and with full knowledge of its significance. I agree to pick up any unused medication within two weeks of the last day of school, or it shall be destroyed. I agree to notify the school administrator immediately if there is any change in my student's status or physician's orders.

Parent's Signature: _____ **Date:** _____

Parent's Signature: _____ **Date:** _____

School Administrator's Signature: _____ **Date:** _____