



**SAINT MARTIN**  
DE PORRES *High School*

**PHYSICIAN/AUTHORIZED PRESCRIBER  
REQUEST TO TEST BLOOD SUGAR AT  
SCHOOL**

**Student Name:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**Medical Diagnosis/ Reason for testing blood sugars at school:** \_\_\_\_\_

**Time(s) for testing blood sugar at school:** \_\_\_\_\_

Is student responsible and capable of self-testing? \_\_\_Yes \_\_\_No

May student carry glucometer in school? \_\_\_Yes \_\_\_No

**Special instructions:** Please complete accompanying care plan. If any medication may be needed at school, a medication request form must be completed for each medication.

**Start date:** \_\_\_\_\_ **End date:**  End of school year or  \_\_\_\_\_

**Medications/blood sugar testing routine at home:** \_\_\_\_\_

(List all that apply)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician/Authorized Prescriber Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Telephone

**PARENTS REQUEST AND RELEASE FOR ADMINISTRATION OF  
TREATMENT AT SCHOOL**

I give permission for my child, \_\_\_\_\_, to receive the above treatment at school according to the prescriber's order and school policy. It is understood that St. Martin de Porres High School and all of its personnel are absolved from any liability which might be associated with the administration of such treatment. I understand that the student must supply his/her own glucometer and other necessary supplies. I give permission to the School Nurse to communicate with the prescriber regarding my child's treatment plan.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone (work /cell/ emergency)

Reviewed by Nurse (name): \_\_\_\_\_ date: \_\_\_\_\_