



BRIDGE Elementary

DIABETES MEDICATION POSSESSION FORM

Name of Student: _____ DOB: _____

Address: _____ Home Phone: _____

Parent/Guardian: _____ Cell Phone: _____

Work Phone: _____

Emergency Contact: _____ Phone: _____

Licensed Health Care Provider's Statement:

The above-named student is under my care. It is medically appropriate for the student to possess the diabetes medication described below, and the student should be in possession of the diabetes medication at all times. Below is the name of the diabetes medication prescribed or authorized for the student's use as well as other pertinent information:

Name of Medication: _____

Type of Medication: _____

Dosage: _____

Possible Side Effects: _____

Signature of Health Care Provider

Date

Parent/Guardian Authorization:

I am the parent/guardian of the above-named student. I authorize my student to possess the diabetes medication described above and I acknowledge that my student is responsible for, and capable of, possessing the diabetes medication.

I also acknowledge that my student and I understand there are serious consequences, which may include suspension, for students sharing any medications with others.

Signature of Parent/Guardian

Date