INSTRUCTIONS FOR MEDICATION AT SCHOOL

PARENT FILL OUT AND SIGN TOP OF MEDICATION ORDER.

HAVE DOCTOR FILL OUT AND SIGN MEDICATION ORDER.

PARENT ANSWER QUESTIONS AND SIGN THE PARENT RELEASE FORM.

PARENT NEED ONLY SIGN THE INDIVIDUALIZED HEALTH SERVICE PLAN.

MEDICATION MUST BE IN A PHARMACY CONTAINER WITH A LABEL.

PHARMACY LABEL MUST MATCH DOCTOR ORDER.

WHEN ALL STEPS ARE COMPLETE, BRING MEDICATION TO SCHOOL TO BE CHECKED IN BY SCHOOL PERSONNEL. MEDICATION WILL BE GIVEN AT SCHOOL AS SOON AS A SCHOOL NURSE CAN APPROVE IT.

STATE OF LOUISIANA

MEDICATION ORDER

TO BE COMPLETED BY LA, TX, AR, OR MS LICENSED PRESCRIBER

(In most instances, medications will be administered by unlicensed personnel.)

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE.

Student's Name Birthdate

School Grade

Parent or Legal Guardian Name (print):

Parent or Legal Guardian Signature: Date:

(Please note: A parental/legal guardian consent form must also be filled out. Obtain from the school nurse.)

PART 2: LICENSED PRESCRIBER TO COMPLETE.

1. Relevant Diagnosis(es):
2. Student's General Health Status:
3. Medication:
4. Strength of medication: Dosage (amount to be given):

Check Route: ❑ By mouth ❑ By inhalation ❑ Other

Frequency Time of each dose

School medication orders shall be limited to medication that cannot be administered before or after school hours. Special circumstances must be approved by school nurse.

5. Duration of medication order: ❑ Until end of school term ❑ Other
6. Desired Effect:
7. Possible side-effects of medication:
8. Any contraindications for administering medication:
9. Other medications being taken by student when not at school:
10. Next visit is:

Prescriber's Name (Printed) Address Phone and Fax Numbers

Prescriber's Signature Credential (i.e., MD, NP, DDS) Date

Each medication order must be written on a separate order form. Any future changes in directions for medication ordered require new medications orders. Orders sent by fax are acceptable. Legibility may require mailing original to the school. Orders to discontinue also must be written.

PART 3: LICENSED PRESCRIBER TO COMPLETE AS APPROPRIATE FOR ALL PRN MEDICATIONS

Inhalants / Emergency Drugs

Release Form for Students that will Self-administer PRN Medications

Use this space only for students who will self-administer medication such as asthma inhaler.

1. Is the student a candidate for self-administration training? ❑ Yes ❑ No
2. Has this student been adequately instructed by you or your staff and demonstrated competence in self-administration of medication to the degree that he/she may self-administer his/her medication at school, provided that the school nurse has determined it is safe and appropriate for this student in his/her particular school setting? ❑ Yes ❑ No
3. If training has not occurred, may the school nurse conduct a training program? ❑Yes ❑ No

Licensed Provider's Signature Date

Fill out part 3 for all PRN medication

INDIVIDUALIZED HEALTHCARE PLAN for STUDENTS WITH SPECIAL HEALTH CARE NEEDS

(Please attach forms if room is insufficient.)

Student's Name:	Date of Birth:
School:	Grade:

BACKGROUND INFORMATION/NURSING ASSESSMENT (Complete all applicable

Brief Medical History/Specific Health Care ___(Additional information is attached.)

Psychosocial Concerns ___ (Additional information is attached.)	**Family Concerns/Strengths** ___(Additional information is attached.)

GOALS AND ACTIONS Individualized Healthcare Plan (IHP). Attach nursing diagnoses, interventions and evaluation, etc.)

Attach physician's order and other standards for care.

) Procedures and Interventions (student specific)

Procedure	Administered By	Equipment	Maintained By	Authorized/Trained
) Administration of medication	School Nurse or those delegated and trained	Medication & Water	Parent	School Nurse
)				
)				

) **Medications** ___ Attach medication guideline and administration log.	3) **Diet** ___ Additional information attached.
) **Transportation Needs** ___ Additional information is attached.	5) **Class/School Modifications** ___ Additional information is attached.
) **Equipment and Supplies** ___ Parent ___ LEA ___None	7) **Safety Measures** ___ Additional information is attached.

) **Student Participation in Procedures**
___ No ___ Yes (If yes, attach description.) ___ Check if the student is enrolled in a special education program.

CONTINGENCIES _X_ **Emergency Plan** attached ___ **Training Plan** attached	**POSSIBLE ALERTS/Allergies**

AUTHORIZATIONS I have participated in the development of the Health Services Plan and agree with the contents. Please sign and date.

Parent(s)_____ / / Teacher(s)_____ / /

School Nurse_____ / / Other_____ / /

School Administrator_____ / / Other_____ / /

Effective Beginning Date_____ Next Review Date_____

Copies must be provided to the Parent(s), School Nurse, Teacher(s), and Principal.

PARENT/GUARDIAN'S REQUEST AND AUTHORIZATION FOR MEDICATION

(PLEASE PRINT)

STUDENT: _____ **DOB:** _____ **GRADE:** _____

NAME OF MEDICATION: _____

(Directions for administration provided by physician/dentist on reverse side of this parent's request)

ARE THERE SPECIAL INSTRUCTIONS FOR GIVING YOUR CHILD THIS MEDICATION?

_____

LIST MEDICATIONS STUDENT RECEIVES AT HOME: _____

_____

PARENT/GUARDIAN'S CONSENT

1. **I give permission for medication to be withheld on field trips. Yes_____ No _____**
   If my child needs to receive medication on a field trip I understand I must request this in writing to the teacher.
2. I give permission to the school nurse/physician to share medical information about my child with appropriate school personnel. I understand that this information is needed to fulfill their responsibilities.
3. I understand that all medication orders must be renewed at the beginning of each school year or as medically necessary.
4. It is the responsibility of the Parent or Guardian to deliver the medication to school.
5. Have you administered the initial dose at home and have you allowed sufficient time (overnight) for observation of adverse reactions before asking school personnel to administer the medication? **Yes**_____

NOTICE: USE THIS BOX ONLY FOR A STUDENT WHO WILL ADMINISTER HIS/HER OWN MEDICATION, SUCH AS AN ASTHMA INHALER, MIGRAINE MEDICATION, ETC.

Do you give permission for your son/daughter to self-administer medication if the school nurse determines it is safe and appropriate in the school setting? Yes: ____ No: _____
Do you feel that your child is sufficiently responsible and informed to determine his/her need for this medication and administer his/her own medication? Yes: ____ No: _____
Do you assume responsibility for your child's actions in his/her self-management of medication at school? Yes: ____ No: _____
Do you understand that regular medication orders must be provided for students who self-administer medication at school? Yes: ____ No: ____

**** We understand that the Jefferson Davis Parish School Board and its employees shall incur no liability as a result of injury sustained by the student from self-administration of medications.***

_____ _____/_____/_____

Parent/Guardian Signature **Date**