Louisiana Academic Health

School Clinic Name:_____

School Term:_____

Parent/Guardian Request and Authorization for Administration of Medication

Student:_____Date of Birth:_____

Name of Parent/Guardian:_____Phone:_____

Address:_____

Emergency Contact

Name:_____Relationship_____Phone:_____

Name of Doctor/Dentist:_____

Name of medication to be given:_____

List any allergies and reactions:_____

Parent/Guardian's Consent

I hereby request and give permission for the school nurse or designated trained unlicensed person, to administer the above medication to the above student prescribed by above MD.

Yes____No____

I give permission to the school nurse to share with appropriate school personnel information (such as adverse side effects) related to the prescribed medication as the nurse determines necessary for my son's/daughter's health and safety.

Yes____No____

I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up within two weeks following termination of the order or two weeks beyond the end of the current school term.

Yes____No____

I have administered the initial dose ordered at home and have allowed sufficient time for observation of adverse reactions before asking school nurse to administer the medication.

Yes____No____

All answers above must be yes before the medication may be administered at school.

Signature of Parent/Guardian_____ **Date**_____

FINAL 11/06

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.

Inhalants / Emergency Drugs

Release Form for Students to be Allowed to Carry Medication on His/Her Person

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