FINAL 11/06

STATE OF LOUISIANA

MEDICATION ORDER

P.O. Box 32000
SHREVEPORT, LA 71130-2000

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

CADDO PARISH SCHOOL BOARD
P. O. Box 32000; 1961 Midway Street
Shreveport, Louisiana 71130-2000

(THIS SIDE TO BE COMPLETED BY PARENT OR GUARDIAN)

NAME OF STUDENT____________________________DATE OF BIRTH______________SEX________

SCHOOL_____________________________GRADE______TEACHER__________________________

NAME OF PARENT/GUARDIAN____________________________PHONE(hm)__________________

ADDRESS____PHONE(wk)__________________

Other persons to be notified in case of emergency if parent/guardian is unavailable:

NAME____________________Relationship__________Phone(hm)__________Phone(wk)__________

STUDENT ALLERGIES:(List medication, food, etc. student is allergic to)______________________

____

PARENT/GUARDIAN'S CONSENT

1. I hereby give permission for the school nurse or the designated unlicensed person, trained to administer medication at school, to give the following:
   ____________________ to ____________________ prescribed by: ____________________
   (Name of Medication) (Name of Student) (Name of Doctor or Dentist)
2. Yes___ I give permission to the school nurse to share with appropriate school personnel, physicians or medical facility, information relative to the prescribed medication administration as the nurse determines necessary for my son's/daughter's health safety.
3. Yes___ I understand I may retrieve the medication from the school at anytime 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.
4. I have administered the initial dose of ordered medicine at home and have allowed twelve (12) hours for observation of adverse reactions before asking school personnel to administer the medication. Yes___No____

NOTE: All answers above must be "YES" before unlicensed personnel may administer the medication at school, unless other arrangements have been agreed on by parents and nurse.

5. SPECIFIC EMERGENCIES:

IF YOU SEE THIS	DO THIS

I am aware that if my child has an emergency in school and I am not available, the school principal or alternate will have my child transported to the emergency room. I will be responsible for payment of emergency care.
Hospital of choice______________________________Physician______________________________

NOTICE: USE THIS BOX ONLY FOR A STUDENT WHO WILL ADMINISTER HIS/HER OWN MEDICATION: SUCH AS AN ASTHMA INHALER. STUDENT WILL BE REQUIRED TO RECORD EACH DOSE.

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 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

SIGNATURE OF PARENT/GUARDIAN______________________________DATE______________

Relationship to Student______________________________RX Number______________________