School Health Office
Medication Administration at School
(Parental Permission)

I __________________________________give permission for my child to receive the medication as prescribed
Parent/ Legal Guardian Signature
by doctor/dentist. I understand that the medication may be given by non-licensed, but trained school personnel.

1. I give permission for my child to self medicate, if after assessing the student's health status in the school setting, the school nurse and/or school physician determines that the prescribed medication can be taken safely by my child.
2. I give permission to the school nurse/school 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 I may retrieve the medication from school at any time and that the medicine will be destroyed if it is not picked up within seven (7) days following termination of the doctor's orders or by the last day of school.
4. I understand that all medication orders must be renewed at the beginning of each school year or as medically necessary.
5. I understand that the doctor and parent/legal guardian are responsible for notifying the school in writing whenever the medication order changes. I can obtain medication forms from the school nurse.
6. I understand that facsimile (fax) Physician /Dentist Orders can be accepted by the school, if they are sent directly from the doctor's office to the school nurse. Legibility may require mailing original to the school.
7. It is my responsibility to deliver the initial supply of: ______________________________
Print Name of Medication
to the school nurse and subsequent supplies to the individual responsible for giving my child medication.

____ ____/____/______
Parent/Guardian Signature ***Date***

Instructions:

Parent: 1. Complete a parental permission form for each medication to be given at school.
Physician/Dentist Only: 2. Complete doctor/dentist order for each medication to be given at school.
School Nurse: 3. Attach copy of Medication Plan and Emergency Medication Plan.
School Nurse: 4. Copy to individual designated to administer medication.
School Nurse: 5. File copy in student health record.

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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