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

St. Aloysius Catholic School

Parent/Legal Guardian Consent for Medication Administration at school

NOTE: State of Louisiana Medication Order Form is also required for medications to be administered at school.

Name of Student: (print) _____Birth date: _____Homeroom: _____
Name of Parent/Guardian: _____Address: _____
Home Phone: _____Work Phone: _____Cell Phone: _____
List ALL medications to be given at school: _____
List ALL allergies for this student: _____
Other medications taken at home: _____
Special instructions for giving medication: _____

1. Have you received and understand the SAS School Medication Policy? Yes_____ No_____
2. Do you give permission for the school nurse to share with designated unlicensed personnel information about your child relative to medication administration, as the nurse deems necessary? Yes_____ No_____
3. Do you understand that you may retrieve the medication from school at any time? Yes_____ No_____
4. Do you understand that medication will be destroyed if not picked up within one week following the end of the school term, or when medication has been discontinued? Yes_____ No_____
5. Have you administered a dose at home and observed your child for 24 hours for an adverse reaction, before the medication can be given at school? Yes_____ No_____
6. Do you consent for a teacher or other non-licensed personnel of SAS to administer medication(s) on a field trip? (Please notify the school nurse at least one day prior to a field trip.) Yes_____ No_____

Answers to the above questions must be "yes" before medication can be administered at school.

Complete the following section ONLY if the Physician Medication Order (Part 3) is completed, AND you wish for your child to CARRY HIS/HER OWN emergency medications (inhaler/epinephrine) at school:

1. Do you give permission for your child to carry and self-administer emergency medication(s) if the school nurse determines that it is safe and appropriate in the school setting? Yes_____ No_____
2. Do you believe that your child is sufficiently responsible and informed to self-administer his/her own medication? Yes_____ No_____
3. Do you assume responsibility for your child's actions regarding his/her self-management of medication in the school setting? Yes_____ No_____
4. Has your physician completed Part 3 of the Physician Medication Order? Yes_____ No_____

Answers to the above questions must be "yes" before SAS will allow a student to carry emergency medications. The state of Louisiana laws ONLY allows self-administration of EMERGENCY medications. (Inhalers/Epinephrine).

I understand and agree that St. Aloysius Catholic School and its employees are not responsible for any unintentional mistakes or oversights in keeping or giving my child medication. I agree to hold the school employees free and harmless from liability from injuries that might occur as a result of the administration of medication(s) to my child.

_____ _____

Signature of Parent/Guardian Date