



PARISH SCHOOL SYSTEM  
WAYNE SAVOY, SUPERINTENDENT

STUDENT ASSESSMENT

**TO BE FILLED OUT BY PARENT/LEGAL GUARDIAN**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Parent/Legal Guardian's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Business Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_  
Name of Student's Physician: \_\_\_\_\_  
Physician's Address: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_  
Food/Drug/Other Allergies: \_\_\_\_\_

**ONLY INDICATE ANY HEALTH CONDITION(S) THAT HAVE BEEN DIAGNOSED BY A PHYSICIAN.**

CONDITION	YES	NO	CONDITION	YES	NO
ADD			Heart		
ADHD			Hearing Loss		
Arthritis			Hemophilia		
Asthma			Hepatitis		
Brain Injury			Immunodeficiency Disease		
Breathing Disorder			Leukemia		
Cancer			Migraines		
Cerebral Palsy			Mononucleosis		
Cystic Fibrosis			Nosebleeds (Frequent)		
Depression			Sickle Cell		
Diabetes			Seizures		
Down's Syndrome			Spina Bifida		
Eating Disorders			Shunts		
Gastrostomy			Tourettes		
Headaches (Frequent)			Tracheostomy		
Head Injury			Vision Loss		

Other/Explanation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any/all medications being taken by student: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent/Legal Guardian's Signature

\_\_\_\_\_  
Date

*All children are important to us.*

**PARENT/LEGAL GUARDIAN'S REQUEST AND AUTHORIZATION FOR MEDICATION  
IN LOUISIANA PUBLIC SCHOOL SYSTEMS  
(please print)**

STUDENT: \_\_\_\_\_ DOB: \_\_\_\_\_ GRADE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TEACHER: \_\_\_\_\_

PARENT/LEGAL GUARDIAN NAME: \_\_\_\_\_ SCHOOL: \_\_\_\_\_

PHONE: (Home) \_\_\_\_\_ (Business) \_\_\_\_\_

**OTHER PERSONS TO BE NOTIFIED IN CASE OF EMERGENCY:**

NAME _____	RELATIONSHIP _____	PHONE _____
NAME _____	RELATIONSHIP _____	PHONE _____

NAME OF MEDICATION: \_\_\_\_\_

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

LIST KNOWN ALLERGIES: \_\_\_\_\_

ARE THERE SPECIAL INSTRUCTIONS FOR GIVING YOU CHILD THIS MEDICATION?

\_\_\_\_\_

LIST MEDICATIONS STUDENT RECEIVES AT HOME: \_\_\_\_\_

\_\_\_\_\_

1. Do you give permission for the school nurse to share with designated trained unlicensed personnel information about your child relative to medication administration as the nurse deems necessary?

YES: \_\_\_\_\_ NO: \_\_\_\_\_

Any restrictions on this release? \_\_\_\_\_

2. Do you understand that this medication will be destroyed if not picked up at the end of the school term or when the medication orders are discontinued?

YES: \_\_\_\_\_

3. 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: \_\_\_\_\_

All answers above must be "yes" before the medication can be administered at school by unlicensed trained personnel.

4. Do you agree to have your child's medication dosage withheld while on a field trip?

YES: \_\_\_\_\_ NO: \_\_\_\_\_ (Medication can **not** be withheld for life-threatening conditions)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian's Signature

## 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  No2. 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  No3. If training has not occurred, may the school nurse conduct a training program?  Yes  No\_\_\_\_\_  
Licensed Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_

## ROLE OF THE PARENT/LEGAL GUARDIAN IN THE ADMINISTRATION OF MEDICATION AT SCHOOL

The **parent/legal guardian** who wishes medication to be administered at school to his/her child has the following responsibilities:

- A. To obtain a written order for **each** medication to be given at school, including **annual renewals at the beginning** of the school year. The new orders dated **before** July of that school year will **not** be accepted. *No corrections will be accepted on the physician's medication order form. Alteration of this form in any way or falsification of the signature are grounds for prosecution. Orders for multiple medications on the same form, an incomplete form, or a form with a physician's stamp, will not be accepted. **FAXED ORDERS MAY BE ACCEPTED; ORIGINAL ORDERS MUST BE RECEIVED WITHIN (5) BUSINESS DAYS.***
- B. To obtain a prescription for **all medications** to be administered at school, including medications that might ordinarily be available over-the-counter. **Only the physician or his/her staff may write on the medication order form. This form must be signed by the physician/dentist/certified nurse practitioner.**

**Before leaving the physician's office check the medication order form against the prescription to make sure they match exactly. (Example: times, dosage, etc.) The labeled prescription bottle must match the medication order before medication can be administered in the school setting.**

- C. To arrange for the safe delivery of the medication to and from school (**by a responsible adult**), in a **properly labeled container** as dispensed by the pharmacist. **The parent/legal guardian will need to get two containers for each prescription from the pharmacist in order that the parent/legal guardian, as well as the school, will have a properly labeled container. If the medication container is not properly labeled, the medication will not be given.**
- D. To provide an authorization form that contains the following information:
1. the student's name;
  2. clear instructions for **school administration**;
  3. Rx number, if any;
  4. current date;
  5. students' diagnosis;
  6. **name, amount of each school dose, time of school administration, route of medication, and reason for use of medication**;
- (over)
7. physician's or, or dentist's or certified nurse practitioner's name;

8. the parent's/legal guardian's printed name and signature;
  9. parent's/legal guardian's emergency phone number;
  10. statement granting or withholding release of medical information.
- E. To provide a list of all medications the student is currently receiving at home and at school.
  - F. To list names and telephone numbers of persons to be notified in case of a medication emergency in addition to the parent/legal guardian and licensed physician/dentist/certified nurse practitioner.
  - G. To provide no more than a **20 school day supply** of medication, in a **properly labeled container**, to be kept at school.
  - H. To administer the **initial dose** of a medication **outside the school jurisdiction** with sufficient time for observation for adverse reactions.
  - I. **To cooperate in counting the medication** with the designated personnel who receives it and sign the Drug Receipt form.
  - J. To cooperate with school staff to provide for safe, appropriate administration of medication to the student, i.e., provide information such as positioning, and suggestions for liquids or foods to be given with the medication.
  - K. To assist in the development of the emergency plan.
  - L. **To comply with written and verbal communications regarding school policies.**
  - M. To grant permission for school nurse/physician/dentist/certified nurse practitioner consultation.
  - N. To remove, or give permission to destroy unused, contaminated, discontinued, or out-of-date medication according to the school guidelines.
  - O. To provide medication orders for field trips extended outside school hours. The medication orders must cover the dosage(s), time(s), and medication(s).
  - P. To provide medication orders(s) for extended day attendance (before and/or after school). The medication orders must cover the dosage(s), times(s), and medication(s).

**PARENTS CAN PICK UP THE MEDICATION PACKETS AT THEIR CHILD'S SCHOOL SITE OR AT THE NURSING DEPARTMENT (337-217-4260) LOCATED AT THE ROSTEET ANNEX ( 2423 6<sup>TH</sup> STREET- UPSTAIRS ROOM 20, LAKE CHARLES, LA).**