Dear Parent/Legal Guardian:

As a general principle, medication shall not be given at any school. However, in extreme cases when the taking of medication is necessary for a child to be able to attend school safely, state law requires certain conditions to be met. These specified conditions have been put in place by the State Board of Elementary and Secondary Education and the Louisiana State Board of Nursing to ensure the health, safety, and welfare of children who need medication during the day.

**AT THE BEGINNING OF EACH SCHOOL YEAR AND ANYTIME THERE IS A CHANGE IN MEDICATION (I.E., DOSAGE OR TIME) A NEW PHYSICIAN/PARENT-LEGAL GUARDIAN REQUEST FORM MUST ACCOMPANY THE NEW MEDICATION. UNDER NO CIRCUMSTANCES WILL A PARENT BE ALLOWED TO MAKE CHANGES IN DOSAGE OR TIME OF MEDICATION WITHOUT A WRITTEN PHYSICIAN'S ORDER.**

The requirements are as follows:

1. Physician/parent-legal guardian medication request form must be completed by a physician and parent/guardian and returned to the school office for all medication given in school setting **INCLUDING MEDICATIONS NORMALY CONSIDERED OVER THE COUNTER (EX. Tylenol, Benadryl, Advil).**
2. Orders for multiple medications on the same form, an incomplete form, or a form with a physician’s stamp will not be accepted.
3. **NEW** written medication orders are required for each medication, to be given at school, which must be dated after July 1st of the upcoming school year, even yearly renewal medications.
4. The physician/parent-legal guardian medication request form **MUST BE SIGNED BY THE PHYSICIAN.**
5. Only oral, premeasured inhalant, topical ointment for diaper rash, and emergency medications shall be administered at school by unlicensed personnel. Antibiotics and other short-term medication including non-prescription medications shall not be given.
6. **Medication must be delivered by a parent/legal guardian only.** Students are NOT allowed to transport or have medication in their possession without school nurse approval. Teachers and principals have the right to take medications and notify the parent.
7. The parent/legal guardian must count and document the amount of medication delivered to the school with the designated school personnel.
8. **NO MORE THAN A (20) TWENTY DAY SUPPLY OF MEDICATION SHALL BE BROUGHT TO THE SCHOOL.**
9. The parent/legal guardian must provide the school with contacts in case of medical emergency: this includes names and current up to date telephone numbers.
10. **THE PARENT/LEGAL GUARDIAN MUST ADMINISTER THE FIRST DOSE OF MEDICATION OUTSIDE OF THE SCHOOL JURISDICTION WITH SUFFICIENT TIME FOR OBSERVATION FOR ADVERSE REACTIONS BEFORE THE STUDENT WILL BE ALLOWED TO TAKE THE MEDICATION AT SCHOOL (except for EMERGENCY MEDICATIONS GLUCAGON OR EPI-PEN).**
PARENT AUTHORIZATION/HEALTH INFORMATION FORM

PARENT OR LEGAL GUARDIAN TO COMPLETE

Student Name: _____________________________________________________ Birthdate: _____________________

School: __________________________________________ Grade: __________ Homeroom: ____________________

Parent/Guardian Name (PRINT): _____________________________________ Phone Number: _________________

Emergency Contact Name: ___________________________________________ Phone Number: _________________

I hereby request that the ordered medication be administered by medication certified school personnel. I give permission for the exchange of information between the prescriber, school staff, and school nurse. I understand that I must supply the school with no more than a 20 day supply of medication. I understand that this medication will be destroyed, if not picked up within 2 weeks of the last day of school. I have administered the first dose of medication on: Date: _________________________________ Time: __________________________________

Can your child’s medication dosage be withheld while attending a field trip? □ YES □ NO

PARENT/GUARDIAN SIGNATURE: _______________________________________ DATE: ________________

PLEASE CHECK THE BOX IF YOUR CHILD HAS ANY MEDICAL CONDITION(S) THAT HAVE BEEN DIAGNOSED BY A PHYSICIAN:

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>YES</th>
<th>CONDITION</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD/ADHD</td>
<td></td>
<td>Heart Condition</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td>Blood or Bleeding Disorder</td>
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<tr>
<td>Cystic Fibrosis</td>
<td></td>
<td>Cerebral Palsy</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>Down Syndrome</td>
<td></td>
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<tr>
<td>Gastrostomy (Feeding Tube)</td>
<td></td>
<td>Sickle Cell Disease</td>
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<tr>
<td>Spina Bifida</td>
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<td>Shunt</td>
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<td>Seizures</td>
<td></td>
<td>Cancer</td>
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<td>Arthritis</td>
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<td>Migraines</td>
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<tr>
<td>Insect Allergy (SEVERE)</td>
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<td>Insect Allergy (SEVERE)</td>
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<td>Traumatic Brain Injury</td>
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<td>Tracheostomy</td>
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<td>Breathing Disorder</td>
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<td>Immunodeficiency Disease</td>
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<tr>
<td>Hearing Loss</td>
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<td>Vision Loss</td>
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<tr>
<td>Other (EXPLAIN BELOW)</td>
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</tbody>
</table>

IF YOU CHECK YES, EXPLAIN BELOW:

Other/Explanation:
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Any/All medications taken by student at home and school:
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Parent/Guardian Signature __________________________________________ Date: ________________

Calcasieu Parish School Nurse Signature ____________________________ Date: ________________

Building Foundations for the Future

Nursing Department 2423 6th Street Lake Charles, LA 70601 Phone 337-217-4260 Fax 337-217-4261
**PHYSICIAN/PARENT-LEGAL GUARDIAN MEDICATION REQUEST FORM**

TO BE COMPLETED BY LA, TX, AR, OR MS LICENSED PRESCRIBER

Each medication order must be written on a separate order form. Any future changes in directions for medication ordered requires new medication orders. Orders sent by fax are acceptable. Legibility may require mailing original to the school.

All medication orders must be renewed each school year.

### PART 1 LICENSED PRESCRIBER TO COMPLETE

1. **Student Diagnosis:** ____________________________

2. **Medication:** ____________________________

3. **Strength of Medication:** ____________________________  Dosage (amount to be given): ____________________________

   - Check Route: [ ] By Mouth  [ ] By Inhalation  [ ] Other ____________________________  Time: ____________________________

   - PRN Frequency (check appropriate):  [ ] every 2 hours  [ ] every 4 hours  [ ] every 6 hours

   *Note: The frequency and the time of medication order must be the same at the Rx given. School medication shall be limited to medication that cannot be administered before or after school hours. Special circumstances must be approved by the school nurse.*

4. **Duration of Medication Order:**  [ ] Until the end of school term  [ ] Other: ____________________________

5. **Desired Effect:** ____________________________

6. **Possible Side-Effects of Medication:** ____________________________

7. **Any contraindications for administering medication:** ____________________________

8. **Other medication being taken by student when not at school:** ____________________________

9. **Student Allergies:** ____________________________

   - Prescriber’s Signature with credentials (i.e. MD, NP, DDS): ____________________________

   - Prescriber’s Name (Printed): ____________________________  Date: ____________________________

   - Phone Number: ____________________________  Fax Number: ____________________________

   - Address: ____________________________

### PART 2 LICENSED PRESCRIBER AUTHORIZATION TO CARRY MEDICATION/SELF ADMINISTER

Inhalants/Emergency Drugs Release Form for Students to be Allowed to Carry Medication/Self Administer Medication

1. 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 the school nurse has determined it is safe and appropriate for this student in his/her particular school setting?  [ ] Yes  [ ] No

   - Prescriber’s Signature: ____________________________  Date: ____________________________

### PART 3 PARENT AUTHORIZATION TO CARRY MEDICATION/SELF ADMINISTER

Inhalants/Emergency Drugs Release Form for Students to be Allowed to Carry Medication/Self Administer Medication

1. Do you give permission for your child to self-administer medication at school?  [ ] Yes  [ ] No

2. Do you assume responsibility for your child’s actions in his/her self-management of medication at school?  [ ] Yes  [ ] No

3. I hereby release Calcasieu Parish School Board, its officers, and its employees, from any liability results from my child’s failure to administer the medication as indicated above. **Parent Initials:** ____________________________  **Date:** ____________________________

### PART 4 PARENT WAIVER TO ADMINISTER MEDICATION

I understand and agree that Calcasieu Parish School Board and its employees are not responsible for any unintentional mistakes or oversights in keeping or giving my child medication. I agree to hold Calcasieu Parish School Board free and harmless from liability from injuries that might occur as a results of the administration of medications by school board employees.

**Parent Signature:** ____________________________  **Date:** ____________________________

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*Building Foundations for the Future*

*Nursing Department 2423*

*6th Street  Lake Charles, LA 70601  Phone 337-217-4260  Fax 337-217-4261*