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 6TH STREET- UPSTAIRS ROOM 20, LAKE CHARLES, LA).

FINAL 11/06

STATE OF LOUISIANA

HEALTH INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN EACH SCHOOL YEAR

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE. Parent/Legal Guardian is encouraged to participate in the development of an Individual Health Care Plan if needed. Use additional sheets, if necessary, for further explanation.

Name of School:			Grade:	
Student's Name: Last		First		M.I.
Student's Date of Birth:		Sex: M F	State or Country of Birth:	
Student's Mailing Address:		City:	State:	Zip Code:
Student's Physical Address:		City:	State:	Zip Code:

Name of Mother or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:
Name of Father or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:

Name of child's pediatrician or primary care provider:	Names of medical specialists or special clinics caring for your child:

Parent or Legal Guardian Signature ____________________ Date

Please check the type of health insurance your child has: Private Medicaid/LaCHIP None

If your child does not have health insurance, would you like information on no cost health insurance? Yes No

In case of emergency—if parent or legal guardian cannot be reached—contact the following:

Name Complete Phone Number ( )

My child has a medical, mental, or behavioral condition that may affect his/her school day: No Yes (If yes, please complete Part 2.)

PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD. Parent/Legal Guardian is responsible for providing the school with any medication and may be responsible for providing the school with any special food or equipment that the student will require during the school day. Check with the school nurse to obtain correct medication and procedure forms.

❑ ALLERGIES

Allergy Type:

Food (list food(s)) ____________________

Insect sting (list insect(s)) ____________________

Medication (list medication(s)) ____________________

Other (list) ____________________

Reactions: (Date of last occurrence if yes.)

Coughing (Date:) Hives (Date:) Rash (Date:)

Difficulty breathing (Date:) Local swelling (Date:) Wheezing (Date:)

Generalized swelling (Date:) Nausea (Date:) Other ________ (Date:)

Currently prescribed medications and treatments:

Oral antihistamine(Benadryl, etc.) Epi-pen Other ____________________

❑ ASTHMA

Triggers: Environmental (i.e., tobacco, dust, pets, pollen, etc.) (list) ____________ Other (list) ____________

Does your child experience asthma symptoms with exercise? No Yes

Symptoms:

Chest tightness, discomfort, or pain Difficulty breathing Coughing Wheezing Other ____________

Currently prescribed medications and treatments: ____________________

____

Date of last hospitalization related to asthma ____________ Date of last emergency room visit related to asthma ____________

Does your child have a written asthma management plan? No Yes

Is peak flow monitoring used? No Yes

Name: ____________________ DOB: ________

❑ **DIABETES**

Currently prescribed medications and treatments:

Insulin: Syringe Pen Pump

Blood sugar testing

Glucagon

Oral medication(s) List medication(s) ______________________________

Is special scheduling of lunch or Physical Education required? No Yes

❑ **SEIZURE DISORDER**

Type of seizure:

Absence (staring, unresponsive) Complex Partial Generalized Tonic-Clonic (Grand Mal/Convulsive)

Other (explain) ______________________________

Physical Education Restrictions: No Yes

Medication(s)*:* No Yes List medication(s) ______________________________

Date of last seizure ____________________ Length of seizure ____________________

❑ **OTHER HEALTH CONDITIONS**

Anemia ADD/ADHD Cancer Cerebral Palsy Chicken Pox Cystic Fibrosis

Depression Digestive disorders Emotional/Psychological Juvenile Rheumatoid Arthritis

Hemophilia Heart condition Physical disability Sickle Cell Disease Skin disorders

Speech problems Other (explain)____________

Physical Education Restrictions: No Yes (explain): ______________________________

____

Medication(s)*:* No Yes List medication(s) ______________________________

____

Special procedures required (i.e., catheterization, oxygen, gastrostomy care, tracheostomy care, suctioning): No

Yes (explain):______________________________

____

Special diet required (i.e., blended, soft, low salt, low fat, liquid supplement): No Yes (explain): __________

____

____

Are there anticipated frequent absences or hospitalizations? No Yes

(explain):____________________

❑ **VISION CONDITIONS**

Contacts/glasses

Other ____________________

❑ **HEARING CONDITIONS**

Hearing aid(s)

Other ____________________

❑ **ENVIRONMENTAL ADJUSTMENTS DUE TO A HEALTH CONDITION**

Special school environmental adjustments of the school environment or schedule: No Yes (explain):__________

____

(i.e., seizures, limitations in physical activity, periodic breaks for endurance, part-time schedule, building modifications for access)

Special school environmental adjustments to classroom or school facilities: No Yes (explain):_________

____

(i.e., temperature control, refrigeration/medication storage, availability of running water)

Special safety considerations: No Yes (explain):______________________________

(i.e., special precautions in lifting, positioning, special transportation emergency plan, special safety equipment, special techniques for positioning, feeding)

Special assistance with activities of daily living: No Yes (explain):______________________________

(i.e., eating, toileting, walking)

PART 3: SCHOOL NURSE TO COMPLETE **if parent/legal guardian indicates medical condition.**

______________________________ ____________

School Nurse Signature Date

Notes:

RETURN COMPLETED FORM TO SCHOOL NURSE/HEALTH OFFICE AS SOON AS POSSIBLE

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 ❑ 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

TO BE FILLED OUT BY SCHOOL NURSE

Name of Medication: ____

Diagnosis: ____

Name of person/persons delegated to administer medication:

SEE MEDICATION ADMINISTRATION PLAN FOR TRAINED SCHOOL PERSONNEL

Delegation for Field Trips: **(1) ADMINISTRATIVE DECISION**

(2) PARENT AGREEMENT TO WITHHOLD MEDICATION

Back-up Plan: (if delegatee unavailable): **ADMINISTRATIVE DECISION IF PAREN T DOESN'T AGREE TO WITHHOLD MEDICATION**

Plans for teaching self-administration (if Applicable): **N/A**

Other persons to be notified of medication administration:

TEACHER/S OF ____

***See Attached Physician's Order for Medication Dosage, Frequency, Times to be given, Route of Administration and any other Specific directions concerning Medication Administration.**

Nurse's Signature: ______________________________ **Date:** ____________