MEDICATION ORDER

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

(Medications will be administered by unlicensed personnel.)

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE

Student's Name____DOB________________

Grade_____ Parent or Legal Guardian Name (print)___________________________________

Parent or Legal Guardian Signature____

(Please note: A parent/legal guardian consent form must also be filled out. Obtain from the office.)

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.
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 | 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 medication orders. Orders sent by fax are acceptable. Legibility may require mailing original to the school. Orders to discontinue also must be written.

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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? ☐ Yes ☐ No

____________________________________ ____________________

Licensed Provider's Signature Date

Providence C.A. Parent Permission for Administration of Medication

(To be completed by parent or legal guardian)

Name of Student:________________________________ DOB:___________________

Grade:____Teacher:_________________Guardian:____________________________

Address:________________________________ Home Phone:___________________

MOTHER cell:______________________ FATHER cell:_________________________

MOTHER work:_____________________ FATHER work:_________________________

Alternate Contact:_____________________Relationship:_____________________

Address:_______________________________ Phone:___________Cell:__________

Student Allergies:____

Student Health Needs:____

Parent/Guardian Consent

New orders required for each school year and as orders change

1. I request that a school employee give the following medication to my child:_______________________(name of medication- one per page)
2. I agree to provide the medication in a container labeled by the pharmacy exactly as the physician's order specifies.
3. I understand I may retrieve the medication from the school office at any time and request that the medication be destroyed if it is not picked up within two weeks following termination of the order or one week beyond the end of the current school term.
4. I agree to give the initial dose of ordered medicine at home and observe my child 12 hours for adverse reactions before asking school personnel to administer the medication.
5. I agree that I, or a responsible adult, will bring the prescribed medicine to the school to observe and verify the count and receipt of the medication. (Up to a 35 day supply can be stored at the school.)

6. Other than emergencies, medications cannot be given less than 45 minutes from the end of the school day, as the child must be observed for this period of time.
7. I agree that, whenever possible, medication will be scheduled to be taken at times other than school hours. I understand that only oral, inhalant by pre-measured aerosol, topical ointment, and emergency injectables may be given at school by unlicensed personell. I understand that the use of unit dose packaging is strongly encouraged. I will let my physician know that my child will need a second Epipen/inhaler to keep at school for safety purposes (as a backup).

NOTICE

Use this section only for a student who will administer his/her own medication, such as eye drops/ointments, ear drops, inhaler, or emergency medications.

THE STUDENT WILL BE REQUIRED TO RECORD EACH DOSE IN THE SCHOOL OFFICE.

Yes___ No___ Do you give permission for your son/daughter to self-administer medication?

Yes___ No___ Do you feel that your child is sufficiently responsible and informed to administer his/her own medication?

Yes___ No___ Do you assume responsibility for your child's actions in his/her self-management of medication at school? The school and its employees shall incur no liability as a result of any injury sustained by the student from the self-administration of medications used to treat asthma or anaphylaxis. By signing below and indicating "Yes", this serves as acknowledgement of the above statement.

Signature of Parent/Legal Guardian______________________________

Relationship to Student__________________ Date____________