OUACHITA PARISH SCHOOLS
REQUIREMENTS FOR MEDICATION ADMINISTRATION

Dear Parent/Guardian:

According to Louisiana laws (R.S. 17:436.1), in order for your child to receive medication at school, the following must be on file at the school:

1. The physician's order on the Medication Order Form (must get form from the school). This order form should be completed for both prescription and over-the-counter medication. Any changes in the physician's orders (dosage, time, etc.) will require a new order form. If the child needs to carry an inhaler or Epi-Pen on his/her person at all times, then an additional form will be provided for completion by the physician and parent.
2. A Release of Liability form signed by the parent.
3. Consent and general information
4. Emergency information

If more than one medication is needed, be sure to inform you physician that each medication order should be on a separate Medication Order Form. Annual renewals for continued medications require new orders each school year. Any prescription or over-the-counter medication requires all of the above paper work, even on something as simple as a cough drop. You may come to the school to administer any medication to your child without any paper work. Medication should be administered before or after school whenever possible (ex. Antibiotics). The first dose of any medication must be given outside school jurisdiction, allowing at least 12 hours for the observation for adverse reactions before the student returns to school. All medication at school must have current pharmacy label (even over-the-counter). When there is an order change by the physician, the pharmacy label must also be updated by the pharmacist. The physician's order and the pharmacy label must match exactly (time and dosage). The medication must be delivered to and from school by the parent or responsible adult, in the original container, and the transaction documented and signed. The student may not bring the medication with them to school. NO drops of any kind will be administered at school.

No more than a 25 day supply of medication can be kept at school. All narcotics such as Ritalin, Adderall, Tenex, etc. should be put in a blister pack by the pharmacist. The parent should pick up any unused, contaminated, discontinued or out-of-date medication, or the school employee, according to the written policy, will destroy the medication.

If a student has a physician's order to carry an inhaler or Epi-Pen on his/her person, and uses it while at school, they MUST go to the office as soon as possible to sign the medication log.

If the physician determines that a dose of medication cannot be omitted for a field trip, then as the parent, you have the option of delivering and administering that dose of medication on the field trip.

FOR ALL medication orders, the parent MUST arrange to meet with the school nurse to complete the necessary paper work. The parent should bring the completed physician's Medication Order Form, and the properly labeled medication. The nurse will also assess the student. The school office or nurse will then be able to take on the role of administering the ordered medication.

If any medication is found in a student's possession, whether it is prescription or over-the-counter, the student is subject to disciplinary action. This would include Tylenol, cough drops, Tums, Neosporin ointment, etc. A doctor's order and the parent's consent, without the proper paper work, does not make it permissible. The ONLY EXCEPTIONS are those students who carry and Epi-Pen or inhaler, which has been properly documented. Even if the student has his/her own inhaler or Epi-Pen on their person, it is advisable that the school office be provided with an extra dose for locked storage.

Thank you for your understanding and cooperation.

Sincerely,

Kenneth Slusher

Kenneth Slusher, OPSB Nursing Supervisor

STATE OF LOUISIANA
MEDICATION ORDER
TO BE COMPLETED BY LA, TX, AR, OR MS LICENSED PRESCRIBER

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE

Student's Name: _____

DOB: _____

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: _____ Strength of medication: _Dosage (amount to be given): _____

Route: ☐ By mouth ☐ By inhalation ☐ Other _____ Frequency _____ Time of each dose _____

ALL PRN MEDICATION MUST DENOTE TIME INTERVAL BETWEEN DOSAGE

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.

4. Duration of medication order: ☐ Until end of school term ☐ Other _____
5. Desired Effect: _____
6. Possible side-effects of medication: _____
7. Any contraindications for administering medication: _____
8. Allergies to food or medicine include: _____
9. Other medications taken at home: _____
10. Next visit is: _____

_____ _____ _____

Licensed Prescriber's Name (Printed) Address Phone/Fax Numbers

_____ _____ _____

Licensed Prescriber's Signature Credentials (i.e., MD, NP, DDS) APRN # 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.

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? ☐ 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

_____ _____ _____ _____

Licensed Prescriber's Signature Credentials (i.e., MD, NP, DDS) APRN # Date

Ouachita Parish School Board
Medication Administration Consent / Release from Liability

Student Name: _____ DOB: _____

Parent / Guardian: _____ Phone: _____

I, the parent / guardian, request that the following medication(s) be given to my child at school:

_____ to _____ from _____ to _____
(medication) (student) (date) (date)
as prescribed by _____ under the indirect supervision of the school nurse.
(physician)

_____ I release the OPSB and its employees of any and all liability, injury, or damage related to the administration of this medication at school. I understand a nurse will not always be giving the medicine except in cases where a certain medication/procedure cannot be delegated by the nurse.

_____I agree to release from all liability the OPSB and its employees in regard to allowing my child to carry and self-administer his/her own *emergency* medications. I understand my child is required to notify the nurse / trained school employee and document on the school's medication log when he/she self-administers *emergency* medication at school.

_____I agree to provide the medication in a container properly labeled by the pharmacy including a specific time of administration. I assume all responsibility for mistakes in furnishing an incorrect medication or dosage.

_____I agree that I or a responsible adult will deliver the prescribed medication to the school to observe and verify the count and receipt of the medication. Up to a 25 day supply can be stored at the school.

_____I give consent for the school nurse to assess my child in the school setting to assure the safety of giving this medication.

_____I give permission to the school nurse to share with & obtain from appropriate school personnel, physicians, and all other healthcare sources information (verbal & written) relative to the student's health and/or prescribed medication administration as the nurse determines necessary for my child's health and safety.

_____I understand that I may retrieve the medication from the school at any time and agree that the medication will be destroyed if it is not picked up within two weeks following the termination of the order, one week after the expiration date, or at the end of the school year.

_____I have administered the initial dose of ordered medicine and have observed that child for at least 12 hours for adverse reactions before asking school personnel to administer the medication. For "as needed" medication, I agree to notify school personnel in the office of all doses given before school hours.

_____In the case of a life threatening emergency, 911 will be called immediately and I and/or an emergency contact will be notified. I give permission for the principal or alternate to transport my child to the nearest ER. I understand that I will be responsible for any and all expenses incurred.

My signature indicates that I have read, understand, and agree with the state/OPSB regulations concerning medication administration at school. I have been given the opportunity to ask questions.

SIGNATURE: _____ SIGNATURE: _____
(parent / guardian) (witness)

RELATIONSHIP: _____ DATE: _____

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

PART 1: CONTACT INFORMATION

Student's/Child's Legal Name	Date of Birth	Social Security #

Parent/Legal Guardian _____ Telephone # _____

Mailing Address _____

PART 2: RECORD REQUEST Complete box A **OR** box B below. Both boxes may not be completed on the same form.

A. Specify the records to be released for the treatment date(s) listed below in Part 3:

- ❑ COMPLETE RECORD(S)
- ❑ Discharge Summary
- ❑ History & Physical
- ❑ Operative Report
- ❑ Consultation ❑ Progress Notes
- ❑ Cardiopulmonary **(Indicate EKG, Stress Test, Sleep Study)**
- ❑ Emergency Room
- ❑ Lab
- ❑ Pathology
- ❑ Radiology Results
- ❑ Other _____

_____

B. If initialed below, I specifically authorize release of the following:

Psychotherapy notes and records indicating psychological or psychiatric impairment(s)

_____ Initials of parent/legal guardian

PART 3: AUTHORIZATION This does not authorize the release of the following: drug and alcohol use counseling and treatment and HIV/AIDS and sexually transmitted disease testing and treatment.

I authorize:

Name: _____ (School System)

❑ **TO RELEASE Information TO** **AND/OR** ❑ **TO OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released AND/OR requested.)

Name: _____ (Hospital, Physician, Service Agency, School RN and/or other health provider)

For treatment date(s): _____

The information is to be released for the purpose(s) of:

- ❑ Evaluation to determine eligibility or continued eligibility for special education services
- ❑ Providing physical therapy treatment
- ❑ Providing occupational therapy treatment
- ❑ Designing an individual educational program
- ❑ Determining appropriate placement for treatment needs
- ❑ Other _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the same medical records department receiving this authorization form. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in nine (9) months from the date of authorization. An authorization is voluntary. I will not be required to sign an authorization as a condition of receiving treatment services or payment, enrollment, or eligibility for health care services. Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected under the Health Insurance Portability & Accountability Act of 1996.

_____ _____ _____

Signature of Student or Legal Representative (Parent/Legal Guardian must sign if student < 18) | Date | (Relationship to student)

_____ _____

Signature of Witness | Date