St. Mark's Cathedral School
2785 Fairfield Ave.
Shreveport, LA 71104

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

PARENT/LEGAL GUARDIAN'S REQUEST AND AUTHORIZATION FOR MEDICATION

(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.

_____ Date

_____ Parent/Legal Guardian's Signature

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