ST. BERNARD PARISH SCHOOL BOARD
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

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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

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Licensed Provider's Signature Date