Calcasieu Parish School Board Medication Packet

Page 1:

Role of the Parent/Legal Guardian in the Administration of Medication in the School Setting

- Please keep this page for your records

ALL FORMS BELOW MUST BE RETURNED TO SCHOOL ALONG WITH THE STUDENT'S MEDICATION

Page 2:

Parent Authorization/Health Information Form

- **Must be completed by Parent/Legal Guardian**

Page 3:

Physician/Parent-Legal Guardian Medication Request Form

- **Part 1** – Completed by Physician
- **Part 2** – Completed by Physician
- **Part 3** – Completed by Parent/Legal Guardian

Calcasieu Parish School Board
BUILDING FOUNDATIONS FOR THE FUTURE
Shannon LaFargue, PhD, Superintendent

Dear Parents/Guardians,

RE: MEDICATION AT SCHOOL GUIDELINES AND PROCEDURE

Follow these guidelines to determine the need for administration of medication during school hours. If your child should need to take medication during school hours, approval is needed by the school. All medication must be delivered to and from the school by the student's parent or guardian in the original pharmacy-labeled or manufacturer's container.

1. Short term administration of medicine such as antibiotics and cough syrups can be given before school, after school, and at bedtime rather than during school hours. Eye and ear drops are not permitted at school.

2. If there is a need to take mid-day medicine on a temporary basis either prescription or non-prescription, parent/guardian may bring the medicine to school and **administer it to their own child via the front office.** If this is not possible, follow the procedure outlined in #3.

3. For those students, whose condition is long term and need prescription or non-prescription medication in order to stay in school; or who may need medicine to treat the appearance of symptoms (e.g., headaches); or those students who need emergency medications *(e.g., inhaler and epi-pen),* the following requirements will be followed:

Forms: Parent Authorization/Health Form and Medication Request Form

- **Form I: Completed by the parent or guardian** of the student, indicating the health condition(s) diagnosed by a physician and the permission given to the school district to assist the student in matters set forth in the physician's statement.

- **Form II: Completed by an authorized LA, TX, AR, or MS Health Care Provider** detailing the diagnosis, name of the medication (one medication per form), dosage, time schedules, side effects, and method of administration by which such medication is to be taken. The physician must sign and print name, address, and phone number.

- **All Medication Should Be Adequately Labeled and Prepared in Sealed Container by Pharmacist or Physician with No More than a 20 Day Supply.** Request pharmacist to put the prescription in two separate containers if the medication is to be used both at home and at school. If needed, parent is responsible for "halving" tablets. Student must receive first dose of medication prior to school usage.

- Authorization forms are only good for the current school year, new authorization forms must be submitted every school year dated after July 1st.

Sincerely,
School Nursing Department

Revised 05/2021

Calcasieu Parish School Board

BUILDING FOUNDATIONS FOR THE FUTURE

Shannon LaFargue, PhD, Superintendent

PARENT AUTHORIZATION/HEALTH INFORMATION FORM

PARENT OR LEGAL GUARDIAN TO COMPLETE

Student Name: _____ Birthdate: _____

School: _____ Grade: _____ Homeroom: _____

Parent/Guardian Name (**PRINT**): _____ Phone Number: _____

Emergency Contact Name: _____ Phone Number: _____

If there is a need for school administered medication/procedures, I request that the ordered medication/procedures be administered by certified school personnel. I give permission for the exchange of information between the prescriber, school staff, and school nurse.

Has the first dose of medication been administered at home? ☐ **YES** ☐ **NO** ☐ **N/A**

Can your child's medication dosage be withheld while attending a field trip? ☐ **YES** ☐ **NO** ☐ **N/A**

Parent/Guardian Signature: _____ **Date:** _____

CHECK THE BOX IF YOUR CHILD HAS ANY MEDICAL CONDITION(S) DIAGNOSED BY A PHYSICIAN

CONDITION	YES	CONDITION	YES
ADD/ADHD	☐	Heart Condition	☐
Asthma	☐	Blood or Bleeding Disorder	☐
Cystic Fibrosis	☐	Cerebral Palsy	☐
Diabetes	☐	Down Syndrome	☐
Gastrostomy (Feeding Tube)	☐	Sickle Cell Disease	☐
Spina Bifida	☐	Shunt	☐
Seizures	☐	Cancer	☐
Arthritis	☐	Migraines	☐
Food Allergy **(SEVERE)**	☐	Insect Allergy **(SEVERE)**	☐
Traumatic Brain Injury	☐	Tracheostomy	☐
Breathing Disorder	☐	Immunodeficiency Disease	☐
Hearing Loss	☐	Vision Loss	☐
Other **(EXPLAIN BELOW)**	☐	Genitourinary (Catheter)	☐

If you check YES, explain below:

Other/Explanation: _____

Any/All medications taken by student at home and school: _____

_____ _____

CPSB Nurse Consultant Signature Date

Calcasieu Parish School Board

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Shannon LaFargue, PhD, Superintendent

PHYSICIAN/PARENT-LEGAL GUARDIAN MEDICATION REQUEST FORM

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

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. All medication orders must be renewed each school year

PART 1: LICENSED PRESCRIBER TO COMPLETE

1. Student Name: _____ DOB: _____
2. School: _____
3. Student Diagnosis: _____
4. Medication: _____
5. Strength of Medication: _____ Dosage (amount to be given): _____
   Check Route: ☐ By Mouth ☐ By Inhalation ☐ Other _____ Time: _____
   PRN Frequency (check appropriate): ☐ every 2 hours ☐ every 4 hours ☐ every 6 hours
6. Duration of Medication Order: ☐ Until the end of school term ☐ Other: _____
7. Desired Effect: _____
8. Possible Side-Effects of Medication: _____
9. Any contraindications for administering medication: _____
   _____
10. Other medication being taken by student when not at school: _____
    _____
11. Student Allergies: _____

Note: *The frequency and the time of medication order* ***must be*** *the same as the Rx given. School medication shall be limited to medication that cannot be administered before or after school hours. Special circumstances must be approved by the school nurse.*

Prescriber's Signature with Credentials (i.e., MD, NP, DDS): _____

Prescriber's Name (Printed): _____ Date: _____

Phone Number: _____ Fax Number: _____

Address: _____

PART 2: LICENSED PRESCRIBER AUTHORIZATION TO CARRY /SELF ADMINISTER MEDICATION

Inhalant/Emergency Drug Release to Allow Student to Carry/Self Administer Medication

1. 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 the school nurse has determined it is safe and appropriate for this student in his/her school? ☐**Yes** ☐**No**

Prescriber's Signature: _____ **Date:** _____

PART 3: PARENT AUTHORIZATION TO CARRY/SELF ADMINISTER MEDICATION

Inhalant/Emergency Drug Release to Allow Student to Carry/Self Administer Medication

1. Do you give permission for your child to self-administer medication at school? ☐**Yes** ☐**No**
2. Do you assume responsibility for your child's actions in his/her self-management of medication at school? ☐**Yes** ☐**No**

I hereby release the Calcasieu Parish School Board, its officers, and its employees, from any liability resulting from my child's failure to administer the medication as indicated above. I further hereby release Calcasieu Parish School Board of Calcasieu Parish, Louisiana, its officers, and its employees, from any and all responsibility for adverse effects of this medication and agree to indemnify them, or any of them, against any and all liability, loss or damage they or any of them may incur as a result of my child not properly self-administering the medication.

Parent/Legal Guardian Signature: _____ **Date:** _____