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 The parent should pick up any unused, contaminated, discontinued or out-of-date medication, or the school employee, according to the written policy, will destroy the medication.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,

Orlando Freemont, OPSB Nursing Supervisor

Dear Parent/ Guardian,

Below is a guide to better assist you in getting this medication packet completed correctly. Please remember that a parent or guardian must bring the completed paperwork and medication to Nurse Stanley, or the secretary. **All controlled substances such as Ritalin, Adderall...Etc. Must be in a blister pack. (These are provided by your pharmacist free of charge). No more than a 35 day supply of medication can be brought to the school.** Medication can be in bottles; however, they must have the following: **Name of pharmacy, address and telephone number of pharmacy, prescription number, date dispensed, name of student, Clear directions for use, which match the written prescription, including the route, frequency and other as indicated, Drug name and strength, Last name and initial of pharmacist, Cautionary auxiliary labels, if applicable, and Physician or dentist's name.**

Medication Packet Includes:

Medication Order- This page is to be completed and signed by the physician that is prescribing the medication. If your child takes multiple medications, a medication order form will need to be filled out for each medication prescribed to your child. Medication orders can be faxed to the school nurse, however the **original medication order** must be brought to the school nurse in **5** business days to be kept on file per OPSB guidelines. The order will not be considered an active order until the original it medication order it brought to the school nurse.

Medication Administration Consent- This page is to be completed by you, the parent/guardian. By filling out this page, it allows the school nurse to administer medications to your child. Please fill in the top information, initial each statement, and sign below.

Authorization for release of information- This page is to be completed by you, the parent/guardian. This gives the Ouachita Parish School Nurse permission to contact the prescribing doctor/pharmacist/dentist...etc. for any information that may be needed regarding medication or your child's condition.

Medication Administration Care Plan- The top of this page is to be completed by you, the parent/guardian. This page consists of emergency contact information needed for the school nurse. The school nurse will complete the bottom half.

Please call with any questions!

Thank you,

Calhoun Middle School Nurse,

Drannon Stanley, RN



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 SCHOOLS
Building Bridges to the Future

1600 North 7th Street ◦ West Monroe, Louisiana 71291 ◦ Phone: (318) 432-5000 ◦ www.opsb.net

Orlando Freemont
Safety and Security Director

freemont@opsb.net
318-432-5338

OUACHITA PARISH SCHOOL BOARD
Medication Administration Consent/Release from Liability

I, the legal guardian of _____, request that an OPSB School Nurse or designated unlicensed trained school employee/UDCA administer, monitor or assist as necessary the following medication and/or procedure per health care provider order:

Medication(s): _____ Allergies: _____

From: _____ To: _____ Prescribed by: _____

** I release the OPSB School Nurse and OPSB employees of ANY and ALL liability, injury or damage related to medication administration at school and school related off campus activities including bus transportation. I agree to hold harmless the school and its employees against any claims that may arise relating to the medication administration or self-carry and self-administration of the medication/procedure.

** I understand that my child is required to notify the nurse or school office when he/she self-administers medications at school. I give consent for the school nurse to assess my child and communicate with their physician. The nurse is allowed to share relative written and/or verbal health related information with school personnel. I will notify my child's bus driver of pertinent medical history, medications and instructions.

** I understand that a nurse may NOT always be present on the school premises and that the medication/procedure may be administered/performed by other medication trained school personnel or an unlicensed diabetes care assistant (UDCA). Students will then be sent back to class where observed.

** I agree to provide the correct medication in a properly labeled pharmacy provided *blister pack*. I assume all responsibility for any pharmacy label mistakes. A written and signed (no stamps) matching provider order is required. If faxed, original order must be provided within 5 business days. Discontinued or expired medication will be discarded after 2 weeks. I agree to notify the school nurse of any medication or health changes.

** I understand that a responsible adult must deliver, count and sign in/out any medication with the school nurse or medication trained personnel. Medication cannot be brought to school by a student.

** I have administered the initial dose and have observed for adverse reactions for at least 12 hours. I agree to notify the nurse or office personnel of "as needed" medications given before school hours.

** In the case of an emergency, 911 will be called and a parent will be contacted. I give permission for my child to be transported to the closest ER. I take full responsibility for any/all transportation and other medical expenses incurred.

My signature indicates that I have read, understand and agree with the Louisiana and OPSB policies concerning medication administration at school. I have been given the opportunity to clarify any information and ask questions.

Guardian Sign: _____ Relationship: _____

School Nurse: _____ Date: _____

STATE OF LOUISIANA

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

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: Ouachita Parish School Board (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
- ❑ _____

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

OUACHITA PARISH SCHOOL NURSE PROGRAM
Medication Administration Care Plan

Student Name:	Date of Birth:
Home Address:	Teacher:
Parent/Guardian Name:	Phone:
Emergency Contact #1	Phone:
Emergency Contact #2	Phone:
Doctor:	Phone:
Allergies:	
Omit medication for field trips? YES NO	Parent's Signature:

********** FOR NURSE USE ONLY **********

Diagnosis:		
Characteristics of Diagnosis:		
MEDICATION BEING ADMINISTERED:		
DOSE:	ROUTE:	TIME/FREQUENCY
Desired Effect:		
Goal: To maintain health stability, while at school, to enable this student to benefit from classroom instruction.		
Notes/Assessment:		
Nurse Signature:		Date: