

Ouachita Parish School Board Medication Administration Policy



Only those medications which cannot be given at home before or after school hours are to be administered at school. In accordance with the Louisiana State Legislature the following guidelines must be met for a student to receive medication at school. (Prescription as well as over-the counter)

- Medications must have an OPSB medication order form completed and signed by a physician/dentist. You may obtain an order form from the school office.
- Medication must be brought to the school by a parent/guardian in a current container appropriately labeled by the pharmacy. Label must match the doctor order. No medication can be brought to school by a student. (ex: Tylenol, cough syrup/drops, orajel, antacids, allergy meds)
- Controlled medication must be supplied in a "blister pack".
- A parent/guardian must meet with the School Nurse to sign appropriate medication forms before any medication can be administered at school. Prior to this, a parent must come to school to give the medicine.
- Any change in the medication (ex: time or dosage) requires updated paperwork and new written doctor's order.
- No eye or ear drops can be administered at school.

For further questions or student medication concerns, please contact the school office or school nurse.

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: _____ DOB: _____
School: **West Monroe High School** Grade: _____ Homeroom: _____
Parent/Guardian Name (print): _____ Phone: _____
Parent/Guardian Signature: _____ Date: _____

** Parent Signature indicates agreement with Prescriber order and Student self-administration of medication if indicated below

PART 2: LICENSED PRESCRIBER TO COMPLETE

1. Relevant Diagnosis: _____ Student's General Health Status: _____
 2. Medication: _____ To be given: Daily PRN
 3. Strength: _____ Dose: _____ Frequency: _____ Time: _____
Route: Mouth Inhalation IM SC Other _____
- *School medication orders shall be limited to medication that cannot be administered before or after school hours. Special circumstances must be approved by the School Nurse.
4. Duration of medication order: End of school term Other: _____
 5. Desired effect of medication: _____
 6. Possible side effect of medication: _____
 7. Any contraindications for administering medication: None or _____
 8. Allergies to food or medicine include: _____ None
 9. Other medications taken at home: _____ None
 10. Next visit is: _____ None Scheduled at Present

Licensed prescriber's Name (printed)

Address

Phone/Fax numbers

Licensed Prescriber's Signature

Credentials

APRN #

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 SELF ADMINISTERED DRUGS

Release Form for Student to Carry Medication on His/Her Person

Parent requests student carry and/or self-administer medication at school.

** Student may carry emergency medication on self at school: YES NO

** Student is competent in self-administration of medication at school: YES NO

Licensed Prescriber's Signature

Date



Ouachita Parish School Board
School Nurses Program

Consent/Release for *Emergency* Medication Self Administration
Students to be allowed to carry on His/Her person

_____ ~ _____ ~ _____
Student's name D.O.B. School

TO BE COMPLETED AND SIGNED BY A LICENSED PHYSICIAN:

I hereby certify that it is medically necessary for the above named student to be allowed to have the medication listed below on his/her person on school premises. He/She has been instructed in and understands the purpose, method and frequency of use of the named medicine and the importance of assuring that the medication is kept away from other students.

- Diagnosis: _____
- Allergies: _____
- Medication: _____
- Dosage: _____ Route: _____
- Frequency: _____
- Desired Effect: _____
- Side Effects: _____
- Physician: _____

* _____ ~ _____
Physician Signature Phone/Fax

TO BE COMPLETED AND SIGNED BY PARENT OR LEGAL GUARDIAN:

I understand the parent's role in medication administration at school. I agree to release from all liability the OPSB and/or its employees in regard to allowing my child to carry and self administer the above noted medication. He/She has been instructed in and understands the purpose, method and frequency of its use and the importance of assuring the medication is kept away from other students.

* _____ ~ _____ ~ _____
Parent's Signature Phone Date